STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365864	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Gables of Marysville Health and Rehabilitation	390 Gables Drive Marysville, OH 43040

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to provide required Advance Beneficiary Notices (ABNs) to residents who remained in the facility with Medicare benefit days remaining when skilled therapy services were discontinued. This affected five (#03, #59, #62, #65, and #99) out of five residents reviewed. The facility census was 92. Findings Included:1.Review of the medical record revealed Resident #03 admitted to the facility on [DATE] and remained in the facility after therapy services were discontinued. Review of a Notice of Medicare Non-Coverage (NOMNC) was issued with a cut date of 12/05/25. No Advance Beneficiary Notice (ABN) was present in the medical record.2.Review of the medical record revealed Resident #62 admitted to the facility on [DATE] and remained in the facility after therapy services were discontinued. Review of a Notice of Medicare Non-Coverage (NOMNC) was issued with a cut date of 12/06/25. No Advance Beneficiary Notice (ABN) was present in the medical record.3.Review of the medical record revealed Resident #59 admitted to the facility on [DATE] and remained in the facility after therapy services were discontinued. Review of a Notice of Medicare Non-Coverage (NOMNC) was issued with a cut date of 12/15/25. No Advance Beneficiary Notice (ABN) was present in the medical record.4.Review of the medical record revealed Resident #99 admitted to the facility on [DATE] and remained in the facility after therapy services were discontinued and was noted as per patient request. Review of a Notice of Medicare Non-Coverage (NOMNC) was issued with a cut date of 01/10/26. No Advance Beneficiary Notice (ABN) was present in the medical record.5.Review of the medical record revealed Resident #65 admitted to the facility on [DATE] and remained in the facility after therapy services were discontinued. Review of a Notice of Medicare Non-Coverage (NOMNC) was issued with a cut date of 01/28/26. No Advance Beneficiary Notice (ABN) was present in the medical record.Review of the above clinical records in the electronic medical record (EMR), Point Click Care (PCC) revealed no evidence that an Advance Beneficiary Notice (ABN) had been issued to any of the identified residents at the time therapy services were discontinued.Interview on 02/25/26 at 3:49 P.M. with Social Services #107 verified that the above residents who were discontinued from therapy services remained in the facility with Medicare benefit days remaining. She verified that the facility issued Notices of Medicare Non-Coverage (NOMNCs); however, residents did not receive an Advance Beneficiary Notice (ABN). She further verified that the facility had no documentation identifying which specific therapy services were discontinued or the amount or frequency of the services. She stated there was no additional documentation available regarding Advance Beneficiary Notices (ABNs).

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	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, and review of facility policy, the facility failed to ensure staff performed hand hygiene during meals service and when feeding residents. This had the ability to affect 15 Residents (#06, #09, #12, #13, #14, #18, #40, #46, #48, #50, #52, #70, #74, #81, and #97) that were served and fed meals in the 100/200/300 halls dining room. The census was 92.Findings include: Observation of the meal service in the 100/200/300 halls dining room on 02/23/26 from 12:15 P.M. through 12:37 P.M., revealed one Certified Nursing Assistant (CNA) #217 served all of the residents in the dining room. CNA #217 served meal trays to residents and removed plates and silverware from the trays and opened lids. CNA #217 opened various food items, drinks, condiment packages, soda cans and poured soda into cups of ice. CNA #217 was observed passing a total of 15 meal trays. Continued observation on 02/23/26 at 12:20 P.M., revealed CNA #217 fed Resident #09 a portion of her meal. CNA #217 then moved to Resident #52 and fed her a portion of her meal at 12:22 P.M. CNA #217 did not perform any hand hygiene before feeding Resident #09 or Resident #52. CNA #217 continued to pass meal trays to other residents. At no time during the meal service on 02/23/26 from 12:15 P.M. through 12:37 P.M. was CNA #217 observed performing any hand hygiene. During an interview on 02/23/2026 at 12:39 P.M., CNA #217 verified she had not performed hand hygiene while passing any meal trays and before feeding Resident #09 and Resident #52. The facility identified 15 Residents (#06, #09, #12, #13, #14, #18, #40, #46, #48, #50, #52, #70, #74, #81, and #97) as being served meal trays by CNA #217 on 02/23/26 from 12:15 P.M. to 12:37 P.M. Review of the facility's policy titled Hand Hygiene dated revised 11/28/17 hand hygiene will be properly performed to assist in the prevention of spreading infections. Hand hygiene is a general term that applies to either handwashing or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR).

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, and staff interview, the facility failed to ensure staff fed dependent residents in a dignified manner. This affected two (#09 and #52) out of six residents observed during dining. The facility census was 92.Findings include: 1.Review of Resident #09's medical record revealed an admission date of 05/08/24. Diagnoses included dysphagia, chronic pain, dementia, and hearing loss. Review of a quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #09 had severely impaired cognition and was dependent on staff for eating. 2.Review of Resident #52's medical record revealed an admission date of 08/09/18. Diagnoses included Parkinsonism, major depressive disorder, and psychotic disturbance. Review of a quarterly MDS dated [DATE] revealed Resident #52 had severely impaired cognition and required substantial to maximum assistance eating. Observation on 02/23/26 at 12:20 P.M. Certified Nurse Aide (CNA) #217 was observed feeding Resident #09. CNA #217 was standing beside a resident who was seated at the table in a tilt wheelchair. CNA #217 fed Resident #09 one spoonful of food and moved on to Resident #52 who was seated in a tilt wheelchair at the same table. CNA #217 fed Resident #52 one spoonful of food while standing then moved on to pass more resident meals trays. During an interview on 02/23/26 at 12:39 P.M. CNA #217 verified she had stood while feeding Resident #09 and Resident #52. CNA #217 verified Resident #09 and Resident #52 had not been fed any more of their meal since 12:20 P.M.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to ensure discrepancies in a resident code status was identified and corrected timely. This affected one resident (#80) out of 36 residents reviewed for advance directives. The facility census was 92.Findings include:Review of the medical record for Resident #80 revealed an admission date of 11/27/19 with diagnoses including Alzheimer's disease, delusional disorder, vascular dementia, type II diabetes mellitus, hypertension, and adult failure to thrive.Review of a physician order with a start date of 04/23/20 and a discontinuation date of 02/02/26 revealed an order for Do Not Resuscitate - CC Arrest, which permits lifeˆsaving measures until the resident's heart or breathing stops.Review of the Do Not Resuscitate (DNR) order form dated 11/28/25 revealed Resident #80's guardian elected DNR Comfort Care (DNRCC), which refuses resuscitation measures.Review of the care plan dated 12/01/25 revealed Resident #80 received hospice services with a terminal diagnosis of earlyˆonset Alzheimer's disease.Review of the Significant Change Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #80 was severely cognitively impaired.Review of the physician order dated 02/02/26 revealed an order for DNR Comfort Care.Interview on 02/25/26 at 9:55 A.M. with the Director of Nursing (DON) revealed an audit identified the resident's code status in the electronic record did not match the paper documentation. The DON confirmed the intention was to change the resident's code status to DNRCC when the resident transitioned to hospice on 11/28/25. The DON confirmed a DNRCC order was placed on 02/02/26.A follow-up interview on 02/26/26 at 10:25 A.M. with the DON verified all licensed nursing staff are responsible for ensuring a resident's physicianˆordered code status matches the corresponding paper record.Review of a policy titled Resident Rights: Treatment and Advance Directive, dated 11/22/16 revealed decisions regarding advanced directives and treatment will be addressed with significant change.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff and resident interview, the facility failed to provide follow up care related to audiology services. This affected one (Resident #64) out of two residents reviewed for hearing/vision. The facility census was 92. Findings included:Review of the medical record revealed Resident #64 was admitted to the facility on [DATE]. Diagnoses included cerebral infarction, generalized anxiety disorder, spinal stenosis and paroxysmal atrial fibrillation.Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #64 was cognitively intact, required supervision for eating, substantial assistance for toileting, substantial assistance for bathing, and partial assistance for personal hygiene.Review of the medical record for Resident #64 revealed no documentation of an audiology visit in the past three months.Interview on 02/23/26 at 2:20 P.M. with Resident #64 revealed someone came in several weeks ago to check his ears due to having hearing issues. Resident #64 stated this person said she was going to order ear drops for his left ear and he has not had any ear drops since she was here.Interview on 02/25/26 at 9:34 A.M. with Licensed Social Worker (LSW) #107 verified Resident #64 had consented for all ancillary services including audiology and Resident #64 was not on the list for January 2026 audiology visits. A follow-up interview on 02/25/26 at 10:31 A.M. LSW #107 verified Resident #64 had an audiology visit on 01/29/26 and the facility had not received the provider note from that day and there were no notes in Resident #64 medical record regarding the audiology visit. The audiology notes had been requested today, 02/25/26. Review of Resident #64 audiology progress note dated 01/29/26 for Resident #64 provided today, revealed an exam revealed deeply impacted cerumen left ear. Debrox (drops for earwax removal) was recommended for the left ear and/or follow facility protocol for cerumen management. Review of the medical record for Resident #64 revealed no order for Debrox or any other cerumen management for the left ear.Interview on 02/25/26 at 11:20 A.M. with the Administrator revealed the facility does not have a policy related to ancillary services. A follow-up interview on 02/25/26 at 11:23 A.M. the LSW #107 verified the Audiologist left after the visit and had not informed anyone of the recommendations for Resident #64. LSW #107 verified she checked with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) and both said they were not notified by the audiologist of the recommendation and visit on 01/29/26. Interview on 02/25/26 at 12:00 P.M. the DON stated she received the audiology note via email for Resident #64 but would not provide the email.Interview on 02/26/26 at 7:45 A.M. with the Medical Director #300 verified if audiology recommends Debrox, the providers would have followed the recommendation and ordered it for the resident.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on medical record review, observation, and staff interview, the facility failed to implement a pressure ulcer/injury prevention intervention. This affected one (Resident #13) out of four residents reviewed for pressure ulcer/injury. The census was 92.Findings Included:Review of Resident #13's medical record revealed an admission date of 02/03/24. Diagnoses included chronic respiratory failure, severe protein-calorie malnutrition, heart failure, muscle weakness, peripheral vascular disease, and dementia. Review of Resident #13's care plan dated 01/09/26 revealed a focus area stating the resident was at risk for alteration in skin integrity related to falls, impaired mobility, and prolonged pressure to bony prominences. Intervention for this focus was to encourage and assist resident to elevate heels when in bed as need/tolerated. Review of a Braden Scale assessment for Predicting Pressure Ulcers/Injuries dated 01/27/26 revealed a score of 11.0, which indicated a high risk for developing pressure ulcers/injuries. Review of the current physician's orders list revealed the following active order with a start date of 10/08/24: Encourage/assist resident to float heels off bed as tolerated.Observation on 02/23/26 at 10:56 A.M. revealed a laminated paper sign hung above Resident #13's bed that read Please float my heels.Observation and interview on 02/25/26 at 9:42 A.M. revealed Resident #13's heels lying flat on the mattress while lying in bed. At the time of observation, interview with License Practical Nurse (LPN) #169 stated that the expectation was when Resident #13 was in bed their heels are floated off the bed with a pillow underneath their knees. LPN #169 verified Resident #13's heels were lying flat on the bed and subsequently placed a pillow underneath the resident's knees to float their heels.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure appropriate catheter cleansing was provided to one (Resident #1) during suprapubic catheter care. This affected one (Resident #1) observed during personal care. The facility census was 92.Findings include:Review of the medical record for Resident #1 revealed an admission date of 01/16/25 with diagnoses of atherosclerotic heart disease, Diabetes Mellitus, chronic kidney disease, obstructive and reflux uropathy, and benign prostatic hyperplasia with lower urinary tract symptoms.Review of the care plan dated 03/21/25 revealed Resident #1 had alteration in elimination related to obstructive and reflux uropathy, benign prostatic hyperplasia, chronic kidney disease stage three, and indwelling suprapubic catheter use. Interventions included maintaining enhanced barrier precautions, providing suprapubic catheter care every shift, and changing the catheter and emptying the catheter bag every shift.Review of the physician order dated 12/19/25 revealed catheter care every shift, including cleansing and applying a split drain dressing to the catheter insertion site.Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #1 was cognitively intact, had an indwelling catheter, and required substantial/maximal assistance with toileting.Observation of catheter care for Resident #1 on 02/25/26 from 10:25 AM to 10:32 AM with Licensed Practical Nurse (LPN) #18 revealed the nurse introduced herself, explained the procedure, and had all supplies prepared, including saline bullets, 4x4 gauze pads, one split gauze, tape, and gloves. The nurse closed the blinds, pulled the privacy curtain, washed hands, uncovered the resident and opened the brief to expose the suprapubic catheter. The nurse donned gloves, wetted gauze with saline, and cleansed the skin area around the catheter, which was noted to have some dried red discharge. The catheter tube was wiped from the insertion point away from the body, and the gauze was discarded. Additional saline-moistened gauze was used to cleanse the skin and catheter tubing, with each piece discarded after use. The tube was stabilized at the insertion point as it was cleaned away from the body. The nurse then placed split gauze around the insertion site.Interview at 10:32 A.M. with LPN #18 confirmed the resident was on enhanced barrier precautions due to suprapubic catheter status and that only saline was used for catheter care, soap was not used. The LPN confirmed an Enhanced Barrier Precautions (EBP) sign was posted on the door and PPE was located outside the room.Interview on 02/26/26 at 10:25 A.M. with the Director of Nursing (DON) revealed the incorrect suprapubic catheter care policy had initially been provided, which stated soap and water was to be used to clean a suprapubic catheter. Upon review of the correct policy, it stated to use a facility-approved cleanser. When asked what the facility-approved cleanser was, the DON reported she would need to refer to the policy and was unsure of the approved cleanser. When asked if saline was considered approved, the DON stated that salt water can clean a tube. When asked if saline has antimicrobial properties, the DON provided no answer.Review of the suprapubic catheter care policy dated 04/2018 revealed it is the policy of the facility to provide safe and clinically appropriate care to residents with suprapubic catheters in order to prevent infection. Catheter care shall be provided in accordance with physician/provider orders and facility infection prevention standards, including cleaning the insertion site with a facility-approved cleanser.

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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 observation, staff interview, record review, and facility policy review, the facility failed to ensure appropriate infection control practices were followed during tracheostomy care for one (Resident #111) of one resident reviewed for tracheostomy care. The facility census was 92.Findings include:Review of the medical record for Resident #111 revealed an admission date of 01/29/26. Diagnoses included chronic respiratory failure with hypoxia, encounter for palliative care, unspecified severe protein-calorie malnutrition, and tracheostomy status.Review of the admission Minimum Data Set assessment dated [DATE] revealed the resident had impaired cognition with a Brief Interview for Mental Status score of seven and required extensive to total assistance with activities of daily living.Review of the plan of care dated 02/09/26 revealed the resident was at risk for infection related to tracheostomy status, chronic respiratory failure with hypoxia, and severe protein-calorie malnutrition. Interventions included monitoring for signs and symptoms of infection and providing care per physician orders.Review of physician orders dated 01/29/26 revealed the resident required ongoing tracheostomy care and monitoring. Review of physician orders dated 02/09/26 and 02/18/26 continued to reflect tracheostomy status requiring nursing care and monitoring.Observation on 02/25/26 at 11:12 A.M. of tracheostomy care for Resident #111 revealed Registered Nurse #199 washed her hands in the bathroom sink, donned a gown, gloves, and mask, and gathered tracheostomy supplies. The Registered Nurse did not disinfect the bedside table prior to placing tracheostomy supplies on the surface. The Registered Nurse touched the bed controls with gloved hands and then handled gauze at the tracheostomy site with the same gloves. The Registered Nurse opened sterile supplies, removed her gloves, performed hand hygiene with sanitizer, and donned sterile gloves. While wearing sterile gloves, the Registered Nurse touched the outside of the non sterile saline bottle and then touched sterile cleaning swabs. The Registered Nurse touched the tracheostomy site with gloves that had contacted the outside of the non sterile saline bottle. After cleaning the tracheostomy site, the Registered Nurse touched the outside of new tracheostomy ties that had been placed on the bedside table and touched the television remote control, and then used the same gloves to apply the new tracheostomy ties. When removing the old tracheostomy tie, the Registered Nurse handled the soiled ties with sterile gloves. The Registered Nurse then removed the sterile gloves, performed hand hygiene, donned new gloves, touched the outside of the opened gauze package, and applied new gauze to the resident using the same gloves.Interview on 02/25/26 at 11:39 A.M. with Registered Nurse #199 confirmed the tracheostomy care was performed as observed.Review of the facility policy titled, Tracheostomy Care, Tube Changes and Suctioning dated 04/17/23, revealed tracheostomy care was to be performed consistent with physician orders and infection prevention and control practices. The policy specified that infection prevention and control practices were to be followed throughout the procedure. The policy further specified that tracheostomy suctioning was a sterile procedure, that hand hygiene was to be performed, personal protective equipment was to be applied, sterile gloves were to be donned using sterile technique, and sterile supplies were to be handled in a manner that maintained sterility.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure pharmacy recommendations were reviewed and acted upon. This affected one resident (Resident #72) out of five residents reviewed for pharmacy recommendations. The facility census was 92.Findings include:Review of the medical record for Resident #72 revealed an admission date of 09/20/23 with diagnoses of Alzheimer's disease, dementia, senile degeneration of the brain, bipolar disorder, insomnia, and anxiety disorder.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #72 was severely cognitively impaired, received an antipsychotic and an antidepressant, and last underwent a gradual dose reduction (GDR) on 12/28/23.Review of a pharmacy recommendation dated 02/26/25 revealed the resident had taken Trazodone (an antidepressant) 50 milligrams nightly since September 2023. The resident's Celexa (an antidepressant) was reduced in January, and the resident also received Seroquel (an antipsychotic). The pharmacy noted the resident was due for a gradual dose reduction GDR evaluation. The prescriber selected other, documenting the resident was followed closely by psychiatry and nursing should advise psychiatry regarding GDR recommendations.Review of a pharmacy recommendation dated 05/12/25 revealed the resident received Seroquel 25 mg every morning and 50 mg twice daily and had been on that dosage since November 2024. The pharmacy noted no adverse effects, no psychiatric service notes, and that the resident was due for a GDR. The physician response stated disagree with a directive to follow up with psychiatry.Review of the care plan dated 07/16/25 revealed the resident had a history or diagnosis of depression and/or anxiety, persistent anger toward others, and repetitive physical movements. Interventions included assisting the resident in working through anxieties.Review of a pharmacy recommendation dated 11/11/25 again revealed Seroquel 25 mg every morning and 50 mg twice daily with no adverse effects, no psychiatric notes, and that the resident was due for a GDR. The physician response documented disagree and other, with a note to consult the psychiatry nurse practitioner.Review of a psychiatric note dated 01/08/26 revealed the resident was being seen for an initial comprehensive psychiatric evaluation and medication management.Review of the quarterly MDS dated [DATE] revealed Resident #72 was severely cognitively impaired, received an antipsychotic and antidepressant, and last received a GDR on 11/05/24.Interview on 02/25/26 at 2:32 P.M. with the Director of Nursing (DON) revealed the DON could not locate any psychiatric visit prior to the initial evaluation on 01/08/26 and would need to confirm whether the resident had been seen by an alternate provider.Interview on 02/26/26 at 8:45 A.M. with the DON revealed psychiatric notes prior to 01/08/26 had not be located.Interview on 02/26/26 at 10:25 A.M. with the DON confirmed the resident was not seen by psychiatry until the initial evaluation on 01/08/26. The DON also confirmed that while the nurse practitioner reviewed the pharmacy recommendations, the pharmacy statements indicating the psychotropic regimen was being managed by psychiatry were not accurate at the time, and orders were not placed to obtain a psychiatry consult. As a result, the pharmacy recommendations dated 02/26/25, 05/12/25, and 11/11/25 were not addressed timely when issued.Review of the facility's Medication Regimen Review (MRR) policy dated 11/28/17 revealed the MRR is a thorough evaluation of the resident's medication regimen with the goal of promoting positive outcomes and minimizing adverse consequences. The policy states the physician will document in the medical record that any identified irregularities have been reviewed and what, if any, action has been taken.

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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 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, staff interview, record review, review of online resources from the Centers for Disease Control and Prevention (CDC), and policy review, the facility failed to ensure staff wore appropriate personal protective equipment (PPE) with residents in enhanced barrier precautions (EBP) (infection control measures in Skilled Nursing Facilities requiring gowns and gloves during high-contact resident care to reduce multidrug-resistant organism [MDRO] transmission). This affected two (Residents #01 and #74) observed during personal care. The facility census was 92.Findings include:Review of the medical record revealed Resident #74 was admitted to the facility on [DATE]. Diagnoses included anoxic brain damage, metabolic encephalopathy, other heart failure, and ischemic cardiomyopathy. Review of the medical record revealed Resident #74 had physician orders dated 11/19/25for EBP every shift. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #74 had severely impaired cognition, supervision for eating, dependent for toileting, dependent for bathing, and partial assistance for personal hygiene. Observation on 02/23/26 at 11:28 A.M., revealed Licensed Practical Nurse (LPN) #169 went in Resident #74's room to give medication via gastrostomy tube (GT) and LPN #169 did not have a gown on. Observation on 02/23/2026 at 11:30 A.M., revealed LPN #169 left the resident's room and stated she forgot her stethoscope. Observation on 02/23/2026 at 11:31 A.M., revealed LPN #169 came back in Resident #74's room and did not have a gown on. Observation on 02/23/2026 at 11:32 A.M., revealed LPN #169 performed administration of medications via GT without a gown in place Observation on 02/23/2026 at 11:37 A.M., revealed LPN #169 left Resident #74's room again for a cup and reentered again with no gown on and administered a 30 milliliter (ml) flush. Interview on 02/23/2026 at 11:45 A.M., LPN #169 verified Resident #74 was in EBP. LPN #169 verified she did not wear a gown during GT medication administration. Interview on 02/26/26 at 8:10 A.M., Certified Nursing Assistant (CNA) #266 stated she was not aware of what PPE to wear for which type of resident care. CNA #266 verified there were no signs on the resident's doors who were in EBP to instruct staff on what PPE to don. 2. Review of the medical record for Resident #01 revealed an admission date of 01/16/25 with diagnoses of atherosclerotic heart disease, diabetes mellitus, chronic kidney disease, obstructive and reflux uropathy, and benign prostatic hyperplasia with lower urinary tract symptoms. Review of the care plan dated 03/21/25 revealed Resident #01 had alteration in elimination related to obstructive and reflux uropathy, benign prostatic hyperplasia, chronic kidney disease stage three, and indwelling suprapubic catheter use. Interventions included maintaining enhanced barrier precautions, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365864	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Gables of Marysville Health and Rehabilitation	390 Gables Drive Marysville, OH 43040

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	providing suprapubic catheter care every shift, and changing the catheter and emptying the catheter bag every shift. Review of the physician order for Resident #01 dated 12/07/25, revealed the resident was ordered to be EBP related to an indwelling catheter. Review of the annual MDS 3.0 assessment dated [DATE] revealed Resident #01 was cognitively intact, had an indwelling catheter, and required substantial/maximal assistance with toileting. Observation of Resident #01's room on 02/25/26 from 10:25 A.M. to 10:32 A.M., revealed a small sign on the door frame indicating the resident was in EBP. LPN #18 performed catheter care for resident #01 without donning a gown. Interview on 02/25/26 at 10:32 A.M., LPN #18 verified Resident #01 was in EBP due to a suprapubic catheter and verified there was an EBP sign posted on the resident's door. LPN #18 verified there were PPE supplies located directly outside of the resident's room. LPN #18 verified she didn't wear a gown and should have when providing direct resident care. Interview on 02/26/26 at 10:25 A.M., the Director of Nursing (DON) verified a gown, and gloves should be worn by staff when they were providing direct care on residents who were in EBP. Review of standard and transmission-based precautions (TBP) dated 07/24/24, revealed EBP refers to an infection control intervention designed to reduce transmission of MDRO that employs targeted gown and glove use during high contact resident care activities. Review of online resources from CDC (https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html) dated 06/28/24, revealed EBP are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. EBP involves at minimum gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical device. EBP expands the use of gowns and gloves beyond anticipated blood and body fluid exposures. Review of the policy titled, Standard and Transmission Based Precautions, dated 03/24/24 revealed, information regarding the particular type of precaution to be utilized will be communicated through verbal reports, written in-house communication forms, and signage.