STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365880	A. Building B. Wing	06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roscoe Gardens Skilled Nursing and Rehab	100 South Whitewoman Street Coshocton, OH 43812

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the medical record, interview, and review of facility policy, the facility failed to ensure resident privacy during medication administration.This affected one resident (Resident #45) of three observed for medication administration. Findings Include: Review of the medical record revealed Resident #45 was admitted to the facility on [DATE]. Diagnoses included dementia, transient cerebral ischemic attack, atrial fibrillation, anemia, hypertension, chronic obstructive pulmonary disease, and overactive bladder.Review of the Annual Minimum Data Set assessment dated [DATE] revealed Resident #45 had intact cognition.Observation of medication administration on 06/09/26 at 9:15 A.M. revealed Resident #45 was outside in the smoking tent. Licensed Practical Nurse (LPN) #200 prepared the medication for Resident #45 inside the building, took them outside to the smoking tent and handed Resident #45 the plastic cup of medication in front of the four other residents. LPN #200 did not ask Resident #45 if she had her permission to administer the medications in front of the other four residents. Resident #45 asked LPN #200 why she had to give the medication to her outside in the smoking tent and why she could not wait until she came back inside to take them. LPN #200 just explained to the resident she needed to take the medications. Resident #45 indicated she could not swallow the big white tablet (potassium chloride) and it needed to be broken in half. LPN #200 proceeded to use her bare hand and retrieve the big white tablet out of the plastic mediation cup and break it in half with her bare hands and give it back to the resident to take.On 06/09/26 at 9:17 A.M. an interview with LPN #200 verified she should have asked Resident #45 if she wanted her medication outside or wanted to wait until she came back inside.Review of the facility policy titled, Dignity, dated 09/22 revealed each resident should be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Staff were to promote, maintain and protect residents' privacy, including bodily privacy during assessments with personal care and during treatment procedures.This deficiency is based on an incidental finding discovered during the course of this complaint investigation.

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, review of the controlled substance administration record, interview, and review of the facility policy, the facility failed to ensure narcotic medications were signed out and administered by the same licensed nurse. This affected one resident (Resident #56) of three reviewed for medication administration. Findings Include: Review of the medical record revealed Resident #56 was admitted to the facility on [DATE]. Diagnoses Alzheimer's disease, anxiety disorder, hypertension, congestive heart failure, dementia, and metabolic encephalopathy.Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #56 had severely impaired cognition and had a prognosis of less than six months. Review of the June 2026 physician's orders revealed Resident #56 had an order for lorazepam 1.0 milligrams every eight hours and every 12 hours as needed for restlessness for 90 days. Review of the June 2026 Medication Administration Record (MAR) revealed on 06/09/26 at 6:00 A.M. the lorazepam (brand name: Ativan), a controlled medication, 1.0 milligram was administered by Registered Nurse (RN) #107.However, review of the Individual Controlled Substance Administration record revealed Resident #56 was administered Ativan 1.0 milligrams on 06/09/26 at 6:57 A.M. by Licensed Practical Nurse (LPN) #200. On 06/09/26 at 11:10 A.M. an interview with Licensed Practical Nurse #200 verified she had signed out the lorazepam for Resident #56 when she was doing the shift-to-shift narcotic count with Registered Nurse #107 and Registered Nurse #107 had administered the medication to Resident #56 and signed it out on the MAR. On 06/09/26 at 12:07 P.M. an interview with the Director of Nursing revealed the nurse who prepared the medication should also be the nurse who administers the medication.Review of the undated facility policy titled, Administering Medications, revealed medication should be administered in a safe and timely manner and as prescribed. Step 15 revealed as required or indicated for a medication, the individual administering the medication would record in the resident's medical record.This deficiency represents non-compliance investigated under Complaint Number 3032271.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the medical record, interview, review of manufacture guidelines, and review of the facility policy, the facility failed to maintain a medication error rate of less than five percent when medications were not timely administered before meals as ordered, expired medications were administered, and insulin was administered without priming. Out of 36 opportunities for error, four errors were made to equal an error rate of 11.1 percent (%). This affected one resident (Resident #34) of three observed for medication administration.Findings Include: 1. a. Review of the medical record revealed Resident #34 was admitted to the facility on [DATE]. Diagnoses included diabetes, pemphigus vulgaris, bullous pemphigoid, ocular hypertension, chronic obstructive pulmonary disease, asthma, depression, pain in right knee, anxiety disorder, and insomnia.Review of the Annual Minimum Data Set assessment dated [DATE] revealed Resident #34 had intact cognition. Review of the June 2026 physician's orders revealed Resident #34 had an order for Admelog SoloStar Pen 30 units subcutaneously before meals for diabetes and Novolog FlexPen subcutaneously per sliding scale before meals for diabetes. Observation of the glucometer reading on 06/09/26 at 8:00 A.M revealed the blood glucose level for Resident #34 was 324 milligrams per deciliter (mg/dL) and she would need 8 units of NovoLog per sliding scale. Resident #100 had already eaten 100 percent of her breakfast. Observation of medication administration with Registered Nurse (RN) #110 on 06/09/26 at 8:05 A.M. revealed she prepared medication for Resident #34. The medication screen was colored red for the NovoLog and Admelog insulins, indicating they were late. RN #110 administered both insulins at 8:20 A.M. after Resident #34 had already eaten 100 percent of her breakfast.An interview at 8:30 A.M. with Registered Nurse #110 verified she had given both insulins after the resident had already eaten her breakfast, despite the order for the insulins to be administered before meals. Review of the undated facility policy titled, Administering Medications, revealed medications should be administered in a safe and timely manner and as prescribed. Medications must be administered in accordance with the orders including any required time frames. b. Review of the Resident #34's physician orders revealed the resident had an order for Pepcid 20 milligrams (mg) two times daily for heartburn. Observation of medication administration on 06/09/26 at 8:05 A.M. revealed Registered Nurse #110 retrieved a bottle of Pepcid 10 mg out of the stock over the counter medication bottles in the top drawer of the medication cart and placed two tablets in the medication cup. The bottle had an expiration date of 02/2026.An interview at 8:30 A.M. with Registered Nurse #110 verified the bottle of Pepcid was expired, however she still administered the medication to Resident #110 even after verification with the surveyor that they were expired. Review of the facility's policy titled, Storage of Medication, dated 09/01/21 revealed the facility should store all drugs and biologicals in a safe, secure and orderly manner. Drugs and biological should be stored in the packaging, containers, or other dispensing systems in which they were received. The facility should not use discontinued, outdated or deteriorated drugs or biologicals.c. Review of the June 2026 physician's orders revealed Resident #34 had an order for Admelog SoloStar Pen 30 units subcutaneously before meals for diabetes.Observation of medication administration on 06/09/26 at 8:05 A.M. revealed Registered Nurse #110 placed a needle on the Admelog SoloStar Pen and turned the dial to 30 units and administered the 30 units to Resident #34 without priming the needle prior to administration. An interview at 8:30 A.M. with Registered Nurse #110 verified she had not primed the needle prior to administration. Review of the manufacture's instruction for the Admelog SoloStar Pen revealed in Step #3 to always do a safety test before each injection to make sure the pen is working correctly and to ensure the person gets the correct insulin dose. It stated to select two units by turning the dose selector until the dose pointer is at the two mark, press the injection button all the way in, and when the insulin comes out of the needle tip, the pen was working correctly. Step #4 was to then select the dose and Step #5 was to then inject your dose. This deficiency represents non-compliance investigated under Complaint Number 3032271.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, review of the medical record, interview, and review of the facility policy, the facility failed to ensure controlled mediations were not pre-poured and stored in the top drawer of the unlocked medication cart, without being promptly administered to the resident. This affected one resident (Resident #56) of 13 residents (#3, #9, #12, #26, #32, #33, #35, #45, #46, #47, #48, #51, and #56) who had medication in the Buckeye Hall medication cart #1.Findings Include:Review of the medical record revealed Resident #56 was admitted to the facility on [DATE]. Diagnoses Alzheimer's disease, anxiety disorder, hypertension, congestive heart failure, dementia, and metabolic encephalopathy.Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #56 had severely impaired cognition and had a prognosis of less than six months. Review of the June 2026 physician's orders revealed Resident #56 had an order for lorazepam (brand name: Ativan), a controlled medication, 1.0 milligrams every eight hours and every 12 hours as needed for restlessness for 90 days. Observation on 06/09/26 at 7:12 A.M. revealed both dayshift and nightshift nurses were sitting at the Buckeye Hall nurses station. The medication cart was unlocked sitting in front of the nurse's station. Further observation revealed in the top drawer of Buckeye Cart 1 was a white tablet in a medication cup with no name. An interview at this time with Licensed Practical Nurse (LPN) #200 revealed it was an Ativan for a resident (identified as Resident #56) who was not up yet. She indicated she had it ready in the top drawer because the resident was leaving the facility. LPN #200 verified at this time she should not have pre-poured the medication.On 06/09/26 at 12:07 P.M. an interview with the Director of Nursing revealed the nurses were not to pre-pour medication at any time. Review of the facility's policy titled, Storage of Medication, dated 09/01/21 revealed the facility should store all drugs and biologicals in a safe, secure and orderly manner. Drugs and biological should be stored in the packaging, containers, or other dispensing systems in which they were received. The facility should not use discontinued, outdated or deteriorated drugs or biologicals. This deficiency represents non-compliance investigated under Complaint Number 3032271.

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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 observations, review of the medical record, interview, and review of the facility policy, the facility failed to maintain proper infection control procedures during medication administration. This affected two residents (Resident #34 and #45) of three observed for medication administration. Findings Include:1. Review of the medical record revealed Resident #34 was admitted to the facility on [DATE]. Diagnoses included diabetes, pemphigus vulgaris, bullous pemphigoid, ocular hypertension, chronic obstructive pulmonary disease, asthma, depression, pain in right knee, anxiety disorder, and insomnia.Review of the Annual Minimum Data Set assessment dated [DATE] revealed Resident #34 had intact cognition. Review of the June 2026 physician's orders revealed Resident #34 had an order for Admelog SoloStar Pen 30 units subcutaneously before meals for diabetes and Novolog FlexPen subcutaneously per sliding scale before meals for diabetes. Observation of medication administration on 06/09/26 at 8:05 A.M. revealed Registered Nurse (RN) #110 obtained the glucometer and bottle of test strips out of the top drawer of the medication cart and took them into the room of Resident #110. She placed the glucometer and the bottle of test strips directly on the resident's bed without a barrier, obtained the resident's blood sugar, then left the room and placed the glucometer and bottle of test strips on top of the medication cart without cleaning/sanitizing them. She proceeded to prepare the residents' medications. An interview on 06/09/26 at 8:30 A.M. with RN #110 verified she cross-contaminated the glucometer and bottle of test strips by placing them directly on the resident's bed, then on top of the medication cart without cleaning/sanitizing them. She stated she was going to clean them before she used them again. An interview on 06/09/26 at 12:07 P.M. with the Director of Nursing verified RN #110 should have placed a barrier prior to placing the glucometer and bottle of tests strips onto the resident's bed and she should have sanitized the glucometer after use. Review of the undated facility policy titled, Obtaining a Fingerstick Glucose Level, revealed the purpose of the procedure was to obtain a blood sample to determine the resident's blood glucose level. It also stated to ensure that blood glucose meters intended for reuse were cleaned and disinfected between resident use. Step three of the procedure indicated to place the blood glucose monitoring device on a clean field. Step eight indicated to clean and disinfect reusable equipment, parts and/or devices after each use per manufacturer's instructions. Step 11 indicated to replace the blood glucose monitoring device in storage after cleaning. 2. Review of the medical record revealed Resident #45 was admitted to the facility on [DATE]. Diagnoses included dementia, transient cerebral ischemic attack, atrial fibrillation, anemia, hypertension, chronic obstructive pulmonary disease, and overactive bladder.Review of the Annual Minimum Data Set assessment dated [DATE] revealed Resident #45 had intact cognition.Observation of medication administration on 06/09/26 at 9:15 A.M. revealed Resident #45 had indicated to Licensed Practical Nurse (LPN) #200 that she could not swallow the big white tablet (potassium chloride), and it needed to be broken in half. LPN #200 proceeded to use her bare hands, retrieve the tablet out of the plastic mediation cup and break it in half with her bare hands and gave it back to the resident to take.On 06/09/26 at 12:07 P.M. an interview with the Director of Nursing verified LPN #200 should not have touched the tablet with her bare hands. Review of the undated facility policy titled, Administering Medications, revealed medications should be administered in a safe and timely manner and as prescribed.This deficiency is based on an incidental finding discovered during the course of this complaint investigation.