STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365932	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewood Manor of Lucasville II	10098a Bear Creek Road Lucasville, OH 45648

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, interview and policy review, the facility failed to allow Resident #22 to return to the facility following a discharge to jail and subsequent hospitalization due to the inability to find a safe discharge location. The facility also failed to assist the resident with appropriate and necessary discharge planning to ensure the resident's total care needs were met. This affected one resident (#22) of three residents reviewed for discharge and transfers. The facility census was 68.Findings include: Closed record review revealed Resident #22 admitted to the facility on [DATE] with diagnoses including bipolar disorder, traumatic brain injury, and schizoaffective disorder bipolar type. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22's cognition was moderately impaired. The MDS assessment noted the goal for the resident was to remain in the facility for long term care. The MDS also reflected the resident had physical behaviors directed towards others (examples: hitting, kicking, pushing, scratching, grabbing, abusing others sexually); verbal behavioral symptoms directed towards others (examples: threatening others, screaming at others, cursing at others); and other behaviors not directed towards others (examples: physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily waste, vocal symptoms like screaming, disruptive sounds) all occurring four to six days but less than daily. The behaviors did not put the resident at risk for significant risk for physical illness or injury, did not significantly interfere with the resident's care and did not interfere with the resident's participation in activities or social interactions. The resident's behavioral symptoms did not place other residents at risk for physical injury but did significantly intrude on the privacy or activity of others and significantly disrupted the care or living environment. Review of a facility self-reported incident dated 03/31/26 revealed Resident #22 was involved in a resident-to-resident altercation where Resident #22 was noted to hit the other resident. There was no injury to either resident. The facility concluded the incident was isolated in nature due to delusions/hallucinations Resident #22 was having and noted Resident #22 would be seen by the facility psychologist on the psychologist's next visit. Review of a facility self-reported incident dated 04/24/26 revealed Resident #22 was involved in a resident-to-resident altercation. The report indicated another resident had walked in on Resident #22 while using the bathroom (the privacy curtain had been pulled). This surprised Resident #22 causing him to yell and hit the resident. As a result of the incident, the facility indicated social services would provide Resident #22 with psychosocial support as needed. Review of a nursing note dated 06/02/26 at 10:42 A.M. authored by Licensed Practical Nurse (LPN) #100 revealed Resident #22 had been in an altercation with another resident which was reported to the police. The note included Resident #22 was placed under arrest and left the building with the police.Review of a facility self-reported incident, tracking number 275225 revealed the facility reported an allegation of physical abuse involving two residents (one of which was Resident #22) that occurred on 06/02/26 at 8:45 A.M. Neither resident involved in the incident was documented as the perpetrator of the incident. Based on the facility report of the incident, it did not appear as though any staff had actually witnessed the incident. A brief description (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365932	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewood Manor of Lucasville II	10098a Bear Creek Road Lucasville, OH 45648

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	of the incident revealed Resident #22 and the other resident were having a conversation when Resident #22 allegedly reached out and touched the other resident. There were no identified injuries to the other resident. Resident #22 stated the resident had been running his mouth and he knew he should not have hit him. The other resident denied talking about Resident #22. The police were contacted and after speaking with both residents, Resident #22 was placed under arrest for assault. Review of a Discharge Notice dated 06/03/26 revealed Resident #22 was being immediately discharged from the facility to the local jail due to an emergency existing in which the safety of individuals in the home would be endangered. The notice included the facility would offer assistance in arranging a location for the resident to reside and if assistance was needed, the facility should be contacted. Notification of the right to appeal to the discharge was included along with information on the local ombudsman. Per the Discharge Notice information, this notice was sent to the resident at the local jail.Interview on 06/12/26 at 9:22 A.M. with the Ombudsman revealed she currently had a case open for Resident #22. She was aware the resident had conflict with another resident and the facility was to have interventions in place. She stated Resident #22 and the other resident went outside to smoke and Resident #22 attacked the other resident and the facility called the police and Resident #22 was arrested. The following day, the resident was issued an emergency discharge notice. The Administrator informed the Ombudsman she spoke with corporate and they were willing to take the hit on it. The Administrator stated she needed to keep residents safe and the Ombudsman stated she told the Administrator she agreed and Resident #22 was the facility's resident. The Ombudsman stated discharge to jail was not safe, the hospital was not appropriate and the administrator stated we will take the cite. The Ombudsman said she had called the hospital and the resident's niece for a location update but she had been unable to find out. But she left messages.Interview on 06/12/26 at 11:11 A.M. with the Director of Nursing (DON) revealed there had been incidents of Resident #22 hitting other residents in the facility (03/31/26, 04/24/26 and 06/02/26) with investigations completed and interventions implemented. The DON verified as a result of the incident on 06/02/26 the resident was issued an immediate/emergency discharge and the facility refused to allow the resident to return. During the interview, the DON stated she was not sure why an immediate discharge was issued instead of giving the resident a 30-day discharge notice, considering Resident #22 barely had any incidents according to the facility incident log but stated she just did what she was told. Interview with the Administrator on 06/12/26 at 11:11 A.M. verified the resident was transferred to jail on 06/02/26 and when the judge ordered to release the resident, the facility refused to take the resident back. The Administrator verified the facility issued an emergency discharge notice with the discharge location as jail.Interview on 06/12/26 at 1:16 P.M. with Deputy Clerk (DC) #131 revealed Resident #22 was arrested and his release information stated to contact the facility, but she was unsure if that happened. She stated she did not know the resident's current location because she was not present when he was released from the jail.Interview on 06/12/26 at 1:34 P.M. with the Hospital Case Manager revealed on 06/02/26 Resident #22 had been arrested but was released by the judge (on 06/03/26) so the police wanted him to return to the facility; however, he was not allowed to return per the facility. So, the local police brought Resident #22 to the hospital where he was admitted to wait for nursing home placement. The case manager revealed Resident #22 had told hospital staff that he knew it wasn't right how the facility kicked him out. The Hospital Case Manager also shared the resident said he knew what he did was wrong but he called the other resident that he hit, a bully and the other resident picked on everyone and I had enough. Further interview revealed the resident had remained hospitalized because the facility would not let him return and due to the hospital's inability to find alternate placement for the resident. The case manager indicated the resident had no current medical needs requiring hospital treatment/monitoring.Information obtained as part of the complaint investigation revealed on 06/03/26 (in the A.M.), an Emergency Department Social Worker was contacted by a Sheriff Deputy at the jail stating the Judge had released a patient (Resident #22) who lived at Edgewood Manor of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365932	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewood Manor of Lucasville II	10098a Bear Creek Road Lucasville, OH 45648

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Lucasville. However, Edgewood was refusing to take the patient back and advised that he be taken to (named) hospital. The deputy stated the resident had initially been arrested on 06/02/2026 after assaulting another resident while on a smoke break at the nursing home.Upon his arrival at the emergency department, another social worker (SW) spoke with facility admissions personnel. The facility admissions personnel reported to the SW this was the second time Resident #22 had assaulted the other resident. She stated on 06/03/26 the facility (Edgewood Manor) sent the jail the letter to be given to the resident stating he could not return to the nursing home. The Hospital SW Manager and Director contacted the Area Agency on Aging Ombudsman. The Ombudsman stated she advised the facility to accept the resident back and noted the assault had occurred when the residents were on a smoke break together and indicated since there was a history of a previous assault (while on smoke break both times), the facility should not have permitted the residents to be on smoke break together. The SW Director contacted the facility Administrator who stated the decision was made by corporate leadership to deny the resident re-admission to the facility. The Administrator acknowledged awareness of potential regulatory consequences and stated the facility would accept any resulting citation. The SW wanted it noted that Edgewood Manor did accept behaviorally challenged patients and the resident (Resident #22) had schizophrenia, bipolar disorder and a traumatic brain injury.There were no additional notes in the resident's medical record to reflect communication from the jail, hospital or ombudsman related to the resident's discharge and/or desire for the resident to return to the facility pending adequate and necessary discharge planning or appeal process related to the 06/03/26 discharge notice. In addition, there was no evidence the facility provided any assistance in arranging for an adequate and alternate location for the resident to reside after they refused to allow him to return. Review of a policy titled Resident Transfer and Discharge Policy and Procedure dated 2026 revealed the facility permits each resident to remain in the facility unless the conditions that allow for a transfer or discharge were met; transfers and discharges were properly documented; and transfers or discharges were in a safe manner. Discharging a resident was a violation of their right unless the facility could demonstrate the conditions that allow for discharge were met. Conditions include the transfer or discharge was necessary for the resident's welfare and resident's needs could not be met in the facility; it is appropriate because the resident's health had improved sufficiently so the resident no longer needed the services provided by the facility; the safety of individuals in the facility was endangered due to the clinical or behavioral status of the resident; the health of individuals in the facility would be otherwise endangered; the resident had failed after reasonable notice to pay for stay at the facility.This deficiency represents non-compliance investigated under Complaint Number 3035518.