

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365936	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Liberty Retirement Community of Lima Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 2440 Baton Rouge Avenue Lima, OH 45805	
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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on employee file review, interview, and review of the employee handbook, the facility failed to ensure performance evaluations were completed as required. This affected four (#146, #166, #300, and #304) of four Certified Nursing Assistants (CNAs) reviewed for performance evaluations. This had the potential to affect all 51 residents residing in the facility. The facility census was 51. Findings include: Review of employee file for CNA #146 revealed a hire date of 05/23/25. No performance evaluations were located in the file. Review of employee file for CNA #166 revealed a hire date of 06/19/24. No performance evaluations were located in the file. Review of employee file for CNA #300 revealed a hire date of 03/05/26. No 90 day performance evaluation was located in the file. Review of employee file for CNA #304 revealed a hire date of 04/15/25. No performance evaluations were located in the file. Interview on 07/14/26 at 4:04 P.M. with Human Resources (HR#374) revealed that she was new to the position. HR #374 stated that she would give evaluations to the Director of Nursing (DON) and had not received any back. HR #374 verified the above personnel did not have performance evaluations in CNA #146, #166, #300 and #304's employee files. Review of employee handbook provided by the facility revealed the facility conducts annual employee performance appraisals. The facility conducts 90-day employee performance appraisals for CNAs. This deficiency represents noncompliance investigated under Complaint Number 3045177.		

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on infection log review, staff interviews, and policy review, the facility failed to ensure an appropriate Antibiotic Stewardship Program was established as required. This had the potential to affect all 51 residents who reside in the facility. The facility census was 51. Findings include: Review of infection control log for May 2026 and June 2026 revealed that the facility did not use McGeers criteria for infections to determine if antibiotics were necessary or justified. Interview on 07/15/26 at 2:39 P.M. with Infection Preventionist (IP #206) revealed that if an infection is not cultured she only goes by what the physician ordered. IP #206 verified they do not use McGeers criteria at this facility. IP #206 verified that she had not used McGeers or any other criteria to determine infections since she has held the position. IP #206 stated she has been in the position since December 2025. IP #206 verified she had no idea if the antibiotics given were needed or just ordered. IP #206 verified they are not doing antibiotic stewardship. Review of policy titled Antibiotic Stewardship updated 08/2024 revealed antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program including utilization of McGeer's criteria or equivalent infection screening. This deficiency represents noncompliance investigated under Complaint Number 3044077.		

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the state nurse aide registry, review of electronic mail (email) communications, review of the facility working schedules, review of employee time sheets, observations, staff interviews, and policy review, the facility failed to ensure staff were not working in the facility with abuse findings in the stated nurse aide registry. This had the potential to affect 15 (#16, #17, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30 and #31) residents that reside on [NAME] and [NAME] hallways. The facility census was 51. Findings include: Review of state nurse aide registry revealed Licensed Practical Nurse (LPN #130) was not in good standing and had been found to have committed abuse, neglect, or misappropriation and cannot be employed by a long-term care facility in any capacity. Review of email communications between Ohio Department of Health (ODH) and the facility Administrator dated 07/22/26 confirmed the facility received the notification that LPN #130 was ineligible to work in LTC facilities due to a finding on the nurse aide registry. Review of facility working schedules for 07/22/26 revealed LPN #130 worked 2:00 P.M. to 10:00 P.M. Review of facility working schedules for 07/23/26 revealed LPN #130 worked from 6:00 A.M. to 6:00 P.M. on [NAME] and [NAME] hallway. Review of facility working schedules for 07/25/26 revealed LPN #130 worked from 6:00 A.M. to 6:00 P.M. on [NAME] and [NAME] hallway. Review of facility time punches revealed LPN #130 clocked in and out for the above dates listed. Observation and interview on 07/27/26 at 10:20 A.M. with LPN #130 revealed the nurse was working on [NAME] and [NAME] hallway. LPN #130 informed the surveyor of her [NAME] name. LPN #130 stated that she was not aware that she was not supposed to work at any long-term care facilities due to adverse action on the nurse aide registry. LPN #130 denied being talked to by management on or around 07/22/26. Interview on 07/27/26 at 11:00 A.M. with the Director of Nursing (DON) revealed LPN #130 had an active nursing license, so she believed the nurse was able to work in the facility. During the interview, DON seemed to be under the impression that she did not know LPN #130 could not work due to the finding in the nurse aide registry. DON stated she was confused by the last name in the nurse aide registry for LPN #130. DON was informed by the surveyor that the nurse aide registry listed the [NAME] name of LPN #130 and then the DON confirmed LPN #130 was ineligible to work in long term care facilities. The facility confirmed there are 15 (#16, #17, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30 and #31) residents that reside on [NAME] and [NAME] hallways who LPN #130 provide care for. Review of policy titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property reviewed 10/2024 revealed the facility will do the following prior to hiring a new employee: check the Ohio Nurse Aide Registry (and attempt to check other state registries if the individual is known to have worked in another state) for all potential new employees (licensed and unlicensed) and new volunteers to determine if there is a finding of abuse, neglect or misappropriation of property against the individual prior to the use of that individual. It is the ongoing obligation of all employees to alert facility of any conviction or finding (such as exclusion) that would disqualify them from continued employment with facility under Ohio or Federal law, or the facility's policies. This deficiency represents noncompliance investigated under Complaint Number 3109198.		

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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 observations, staff interviews, and policy review, the facility failed to ensure the proper storage of medications. This had the potential to affect 15 (#16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29 and #30) residents residing on [NAME]/[NAME] hallways and 13 (#1, #2, #3, #4, #5, #6, #7, #8, #9, #49, #50, #51, #52) residents residing on the Tuscan East hallway. The facility census was 51. Findings include: Observation on 07/14/26 at 8:32 A.M. of the medication cart located on [NAME]/[NAME] hallways revealed three bottles of fluticasone sprays undated for a resident that had been discharged . One bottle of artificial tears that was full not in a box with no resident name or date. One box located in the back of the cart for artificial tears empty with a date of 02/12/26. Observation of the medication refrigerator on [NAME]/[NAME] hall revealed a bag containing chicken for a resident, three containers of yogurt, and one can of Dr. Pepper unopened. Interview on 07/14/26 at 8:34 A.M. with Licensed Practical Nurse (LPN #126) revealed that the resident with the fluticasone sprays was no longer at the facility. LPN #126 verified the eye drops were not labeled or dated and assumed the empty box was for those eye drops but could not be sure. LPN #126 verified the food in the medication refrigerator. Observation on 07/15/26 at 6:55 A.M. of the medication cart located on Tuscan East revealed latanoprost ophthalmic solution 0.005 percent (%) with an expiration date of 04/16/26. Interview on 07/15/26 at 7:10 A.M. with Registered Nurse (RN #208) revealed the nurse verified the eye drops were expired and should have been discarded. The facility confirmed there are 15 (#16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29 and #30) residents residing on [NAME]/[NAME] hallways and 13 (#1, #2, #3, #4, #5, #6, #7, #8, #9, #49, #50, #51, #52) residents residing on the Tuscan East hallway who have medications stored in those medication carts. Review of policy titled Medication Storage not dated revealed expired, discontinued and/or contaminated medications will be removed from the medication storage areas and disposed of in accordance with facility policy. Employee or resident food should not be stored in the medication refrigerator. Exception: food used for administration or medications or specifically ordered for a resident by the physician and/or dietician. This deficiency represents noncompliance investigated under Complaint Number 3045177.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations, staff interviews, and policy review, the facility failed to ensure a homelike environment regarding pervasive odors. This had the potential to affect 17 (#32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, and #48) residents residing on the Tuscan [NAME] hallway. The facility census was 51. Findings include: Observation during initial tour on 07/13/26 from 9:12 A.M. to 9:45 A.M. revealed Tuscan [NAME] hallway had a pervasive urine smell throughout the hallway. Observation on 07/13/26 at 1:27 P.M. revealed Tuscan [NAME] hallway had a strong urine smell that permeated the whole hall. Interview on 07/13/26 at 1:35 P.M. with Housekeeper #358 revealed that she was aware of the strong urine smell on Tuscan West. Housekeeper #358 stated that it was coming from a room in the middle of the hallway. Housekeeper #358 stated they clean the room several times a day but the smell just returns. Follow-up observation on 07/14/26 at 7:46 A.M. revealed the strong urine smell remained on Tuscan West. Follow-up observation 07/14/26 at 8:38 A.M. revealed strong urine smell remained on Tuscan West. Interview on 07/14/26 at 8:48 A.M. with Certified Nursing Assistant (CNA #292) verified the strong urine smell on Tuscan [NAME] and the odor permeated the whole hall. CNA #292 stated that it is caused by one resident and the resident refuses to wear briefs therefore she urinates on herself. CNA #292 stated they try and change the linens and chux pads daily and as needed to help with the odor. The facility confirmed there are 17 (#32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, and #48) residents residing on the Tuscan [NAME] hallway. Follow-up observation on 07/14/26 at 2:13 P.M. revealed strong urine smell remained on Tuscan West. Interview on 07/15/26 at 6:11 A.M. with CNAs #276 and #300 verified the strong urine smell on Tuscan West. Follow-up observation on 07/15/26 at 7:21 A.M. revealed strong urine smell remained on Tuscan West. Follow-up observation on 07/15/26 at 9:49 A.M. revealed strong urine smell remained on Tuscan West. Follow-up observation on 07/16/26 at 8:33 A.M. revealed very strong urine smell on Tuscan [NAME] that permeated the whole hallway. The urine odor was stronger about halfway down the hall to the end of the hall. Review of policy titled Quality of Life-Homelike Environment revised May 2017 revealed the facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include pleasant, neutral scents. This deficiency represents noncompliance investigated under Complaint Numbers 3091145 and 3072649.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, resident and staff interviews, and policy review, the facility failed to ensure a resident's call light was in reach. This affected one (#50) of 10 residents reviewed for call light placement. The facility census was 51. Findings include: Review of medical record for Resident #50 revealed an admission date of 08/31/25 with diagnoses including but not limited to dementia, anxiety, and hypertension. Review of minimum data set (MDS) dated [DATE] revealed the resident had moderate cognitive impairment. The resident required supervision or touching assistance for transfers and ambulation, substantial/maximal assistance for oral hygiene, toileting hygiene, shower/bathing, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. Review of physician orders revealed an order for call light in reach at all times while in room. Review of care plan dated 09/02/25 revealed the resident is at risk for falls or falls with major injury related to weakness, spondylosis, dementia, anxiety, and arthritis. Interventions included keep call light within reach and encourage the resident to use it for assistance as needed. Observation and interview on 07/13/26 at 1:28 P.M. with Resident #50 revealed that the resident stated his call light was hooked to his recliner. Upon observation it was revealed that the call light was not hooked to the recliner and was draped over the call light box on the wall out of reach of the resident. Interview on 07/13/26 at 1:35 P.M. with Housekeeper #158 verified the call light for Resident #50 was draped over the call light box on the wall out of reach of the resident. Review of policy titled Call Lights reviewed 03/20/26 revealed when providing care to the resident, be aware to position the call light conveniently for the resident to use. This deficiency represents noncompliance investigated under Complaint Number 3072649.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and physician interviews, and policy review, the facility failed to ensure the physician was notified of laboratory results in a timely manner. This affected one (#54) of three resident reviewed for lab results. The facility census was 51. Findings include: Review of medical record for Resident #54 revealed an admission date of 04/27/26 and discharge date of 05/31/26 with diagnoses including but not limited to chronic respiratory failure, dependence on respirator (ventilator) status, tracheostomy status, pneumonitis due to inhalation of food and vomit, end stage renal disease, dependence on renal dialysis, hypertension, colostomy status, gastrostomy status and osteomyelitis of vertebra sacral and sacrococcygeal region. Further review of medical record for Resident #54 revealed a hospital discharge order on 05/01/26 for vancomycin random level to be drawn on 05/03/26. Hold vancomycin 1-gram intravenous (IV) dose until vancomycin level on 05/03/26. Vancomycin end date will be 05/07/26. Review of nurses note dated 05/01/26 revealed the resident arrived back to the facility via squad. Discharge nurse at facility stated that wound vac was discontinued and per provider at facility it was up to the physician if he would like to continue wound vac or wet to dry dressing daily. Writer spoke with physician and would like to continue wet to dry dressing daily. Residents' vancomycin is also on hold currently due to vancomycin levels are too high. Levels are to be drawn on 05/03/26 and notify Infectious Disease physician of the level. Review of nurses note dated 05/03/26 8:18 A.M. revealed vancomycin level drawn and picked up by the lab. Review of nurses note dated 05/04/26 8:37 A.M. revealed writer contacted the lab regarding the vancomycin level and was informed that the specimen was placed into the wrong-colored tube and would need to be redrawn. Review of nurses note dated 05/04/26 at 12:00 P.M. revealed blood pulled from IV for vancomycin trough. Review of nurses note dated 05/06/26 at 1:58 P.M. revealed writer placed call to Infectious Disease physician to confirm vancomycin trough at 2:00 P.M. with no answer. Message left to call facility back. Review of lab dated 05/04/26 revealed vancomycin trough was 13.7 micrograms (mcg)/milliliter (ml) with a reference range of 10.0-20.0 which indicated the level was in the normal range. Interview of 07/14/26 at 4:30 P.M. with the Director of Nursing (DON) revealed there was no documentation that the vancomycin trough levels were communicated to Infectious Disease (ID) Physician #380. DON verified Resident #54 did not receive vancomycin 1-gram at any time prior to going to the hospital on [DATE] for mucous plug. Interview on 07/15/26 at 1:43 P.M. with ID Physician #380 revealed that Resident #54 was placed on vancomycin for urinary infection. ID Physician #380 verified he did not receive a phone call from the facility until 05/14/26 for him to see the resident regarding his PICC. ID Physician #380 stated that vancomycin was completed at the hospital and was not sure why it was ordered on discharge. ID Physician #380 stated that the vancomycin would not have changed the outcome of the resident and the resident had multiple co-morbidities. Review of policy titled Physician Orders Policy and Procedure dated 05/09/24 revealed execution of order and notifications the nurse that takes the physician order will be responsible for executing the order or provide for the safe hand-off to the next nurse. Notify attending or other providers as appropriate and document contacts in the medical record. This deficiency represents an incidental finding investigated under Complaint Number 3044077		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review, review of a fall investigation, review of a facility self-reported incident (SRI), and staff interview, the facility failed to ensure that adequate supervision was provided on night shift. This affected one (#9) of three residents reviewed for falls. The facility census was 51. Findings include: Review of medical record for Resident #9 revealed an admission date of 01/25/22 with diagnoses including but not limited to chronic respiratory failure with hypoxia, type two diabetes, urinary tract infection, major depressive disorder, migraine, delusional disorders, generalized anxiety disorder, and hypertension. Review of care plan dated 01/25/22 revealed the resident had activities of daily living (ADL) self-care deficit related to chronic respiratory failure, obesity, anxiety, and depression. Interventions included toileting hygiene require weight bearing assistance by staff for toileting, assist with toileting needs, peri-care, and hygiene as needed. Further review of care plan revealed the resident had potential risk for falls or fall with major injury related to chronic respiratory failure, obesity, hypertension, anxiety, depression, and diabetes. Interventions included blood sugar checks for three days, educate resident to use call light for assistance, education to staff on proper procedure of answering call lights, education provided to resident to always use the call light if she is providing her own activities of daily living (ADL), keep bed in lowest position when not providing care, nonskid strips in front of sink to increase traction/stability during transfers, keep environment free from clutter that could contribute to falls, and keep frequently used items within reach. Further review of care plan revealed the resident has bowel incontinence. Intervention included check frequently and as required for incontinence and check resident frequently and assist with toileting as needed. Further review of care plan revealed the resident has mixed bladder incontinence related to mobility, weakness, and oxygen use. Intervention included check frequently and as required for incontinence, wash, rinse, dry perineum, apply barrier cream, the resident uses disposable briefs, and change when soiled and as needed. Review of progress note dated 06/05/26 at 7:20 A.M. revealed that writer was notified by a Certified Nursing Assistant (CNA) that the resident was on the floor in her bathroom and was stating she was there all night. Upon arrival at the resident's room, writer noted the resident laid across the bathroom floor with only a sports bra on. The resident's skin was dry, cold to touch, with dried urine around the resident's body. Writer took vital signs. Resident #9 denied hitting head. Resident #9 was alert and oriented times three. Resident #9 stated that last night around 7:30 P.M. she went to use the bathroom, started to feel dizzy and attempted to self-transfer to wheelchair without calling for help or assistance. When the resident attempted to sit in the wheelchair, she slid off chair and onto her bottom. The resident stated her bottom hurt and when assessed not redness or bruising was noted. The resident was too far away to use call light at the time of the fall and stated she was yelling out for help, but nobody heard her. Review of nursing note dated 06/05/26 at 11:52 A.M. late entry revealed after interdisciplinary team (IDT) review and root cause analysis, the resident did not call for help getting ready for bed and slipped in the bathroom. Floor strips on the floor in front of the toilet were not long enough so were replaced with longer strips. Resident #9 was educated to call for help. Therapy to see the resident. Review of SRI investigation completed on 06/05/26 revealed interview at 7:40 A.M. with Licensed Practical Nurse (LPN #114) informed the former Director of Nursing (DON) that Resident #9 was found lying on her bathroom floor and the resident stated that she was on the floor all night. LPN #114 stated the resident was naked, cold, and had dried urine on the floor around her. LPN #114 stated the resident was assessed with no injuries. Interview with Resident #9 revealed that she was getting ready for bed last night (06/04/26) and slid (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	onto the floor. Resident #9 stated she lay there all night. Resident #9 denied getting her bedtime medications. Resident #9 stated that she did try yelling for help and banging on the wall. Resident #9 stated that staff found her this morning on the bathroom floor. Interview with CNA #300 revealed that she found Resident #9 lying on the floor in the bathroom, not wearing any clothes, body was cold, clothes she had on the day before (06/04/26) were lying on the bathroom floor. CNA #300 stated that a box was lying on top of Resident #9's bed last night when she left and was still lying on the bed in the same spot this morning and didn't appear that the resident used the bed last night. Phone interview with Agency Nurse (AN #381) revealed that she gave Resident #9 her evening medications when she was sitting at the table in the dining room. AN #381 stated she did not go into Resident #9's room anytime during the night. AN #381 stated that she usually just did her own thing giving medications and did not go into resident rooms unless the aides are on break or if multiple call lights are going off. AN #381 signed off on electronic medication administration record (eMAR) at 4:34 A.M. Resident #9's levothyroxine as given. When asked where the resident was at that time, AN #381 stated that she realized she did not give Resident #9 the medication but had signed it off and got side-tracked. As a result, the facility placed the nurse on Do Not Return list so she can no longer pick up shifts at the facility. Former DON reviewed the security camera from 6:00 P.M. to 6:00 A.M. shift and observed CNA #260 wheeling Resident #9 into her room at 7:59 P.M. then left the room right after. No staff was seen entering her room from 8:00 P.M. to 6:00 A.M. Day shift found the resident on the floor at 7:30 A.M. Interview with CNA #382 revealed she was scheduled to work that night shift. CNA #382 stated the CNA #260 had taken Resident #9 back to her room. CNA #382 stated that Resident #9 puts herself to bed. CNA #382 stated the Resident #9's call light never came on so she never went in her room during her shift. CNA #382 was educated that she needed to check on all residents every two hours to make sure they are okay. CNA #382 has been terminated from employment. Interview on 07/27/26 at 1:04 P.M. with current DON revealed that the statements were obtained by the previous DON involving Resident #9's fall. Current DON verified that the statement interview with AN #381 and security camera review were signed off by the previous DON as being factual. DON verified it is common practice and the facilities expectation that all residents are checked on by staff every two hours. This deficiency represents noncompliance investigated under Complaint Number 3045906.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365936	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Liberty Retirement Community of Lima Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 2440 Baton Rouge Avenue Lima, OH 45805	
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 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. Based on record review, review of a facility self-reported incident (SRI), staff interviews, and policy review, the facility failed to ensure medications were administered as ordered. This affected two (#37 and #9) of three residents reviewed for medication administration. The facility census was 51. Findings include: 1. Review of medical record for Resident #37 revealed an admission date of 05/23/26 with diagnoses including but not limited to overactive bladder, other seizures, and chronic pain syndrome. Review of hospital discharge date d 05/23/26 revealed start ciprofloxacin 500 milligrams (mg) twice daily for seven days for urinary tract infection (UTI). Review of past physician orders revealed Resident #37's ciprofloxacin 500 mg was not administered and ordered until 05/27/26 for UTI. Interview on 07/14/26 at 4:30 P.M. with Director of Nursing (DON) revealed no documentation located for the reason Resident #37 was not ordered ciprofloxacin 500 mg twice daily on 05/23/26. DON verified Resident #37 did not receive ciprofloxacin 500 mg twice daily until 05/27/26. Review of policy titled Physician Orders Policy and Procedure dated 05/09/24 revealed the nurse that takes the physician order will be responsible for executing the order or provide for the safe hand-off to the next nurse. Contact laboratory services, radiology services, pharmacy services, therapy or other outside vendors as required to execute the medical order. The medication administration record/treatment administration record (MAR/ TAR) should automatically be updated with the new orders if a schedule has been assigned. Notify attending or other providers as appropriate. Document contacts in the medical record. 2. Review of medical record for Resident #9 revealed an admission date of 01/25/22 with diagnoses including but not limited to chronic respiratory failure with hypoxia, type two diabetes, urinary tract infection, major depressive disorder, migraine, delusional disorders, generalized anxiety disorder, and hypertension. Review of physician orders revealed levothyroxine 150 micrograms (mcg) daily. Review of Medication Administration Record (MAR) for June 2026 revealed levothyroxine 150 mcg was signed off as given on 06/05/26. Review of phone interview done on 06/05/26 during SRI investigation with Agency Nurse (AN #381) revealed AN #381 signed off on electronic medication administration record (eMAR) at 4:34 A.M. that Resident #9's levothyroxine as given. When asked where the resident was at that time, AN #381 stated that she realized she did not give Resident #9 the medication but had signed it off and got side-tracked. As a result, the facility placed the nurse on Do Not Return list so she can no longer pick up shifts at the facility. Interview on 07/27/26 at 1:04 P.M. with DON revealed that the statements were obtained by the previous DON involving Resident #9. Current DON verified that the statement interview with AN #381 and security camera review were signed off by the previous DON as being factual. DON verified AN #381 documented she administered Resident #9's levothyroxine but she actually didn't administer the medication on 06/05/26. This deficiency represents noncompliance investigated under Complaint Numbers 3045906 and 3044077.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365936	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Liberty Retirement Community of Lima Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 2440 Baton Rouge Avenue Lima, OH 45805	
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 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 record review, observation, and staff interview, the facility failed to ensure medications were administered as ordered resulting in two medication errors out of 31 opportunities or a 6.25 percent (%) medication error rate. This affected one (#25) of three residents observed during medication pass. The facility census was 51. Findings include: Review of medical record for Resident #25 revealed an admission date of 05/08/26 with diagnoses including but not limited to glaucoma and legal blindness. Review of minimum data set (MDS) dated [DATE] revealed the resident had moderate cognitive impairment. Review of physician orders revealed timolol maleate ophthalmic solution 0.5 percent (%) instill one drop in both eyes twice daily (allow for five minutes between drops) and brimonidine tartrate ophthalmic solution 0.2% instill one drop in both eyes twice daily (allow for five minutes between drops). Observation on 07/14/26 at 8:06 A.M. of medication pass for Resident #25 revealed the Licensed Practical Nurse (LPN #126) administered one eye drop in both eyes and was proceeding to administer the second eye drop when the resident informed the nurse that she needed to wait a minute and not do them back-to-back. LPN #126 waited one minute and administered the second eye drop into both eyes. Interview on 07/14/26 at 8:20 A.M. with LPN #126 revealed the nurse verified that she administered the eye drops for Resident #25 without waiting five minutes between the drops per physician order. This deficiency represents noncompliance investigated under Complaint Numbers 3045906 and 3044077.		