

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365939	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER Edgewood Manor of Wellston		STREET ADDRESS, CITY, STATE, ZIP CODE 405 North Park Avenue Wellston, OH 45692	
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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interview, the facility failed to ensure as needed psychotropic medications were not prescribed for longer than 14 days without being re-ordered by the physician or discontinued. This affected two residents (#37 and #42) out of the five residents reviewed for unnecessary medications during the annual survey. The facility census was 40. Findings include: 1. Record review for Resident #37 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included anxiety disorder, depression, and acute respiratory failure with hypoxia. Review of the admission Minimum Data Set (MDS) assessment, dated 05/23/25, revealed the resident was assessed to have impaired cognition. Review of the physician's order, dated 05/27/25, revealed an order to administer 25 milligrams (mg) of hydroxyzine (an anti-anxiety medication) every 24 hours as needed. The order did not contain a date to stop the medication and was not discontinued until 06/27/25 (31 days after it was ordered). Interview with the Director of Nursing (DON) on 09/04/25 at 10:05 A.M. confirmed the order for hydroxyzine to be administered on an as needed basis was active for longer than 14 days without being discontinued or re-ordered by the physician. 2. Record review for Resident #42 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included dementia, bipolar disorder, major depressive disorder, anxiety disorder, and schizophrenia. Review of the quarterly MDS assessment, dated 07/10/25, revealed the resident was assessed to have intact cognition. Review of the physician's order, dated 03/29/25, revealed an order to administer 25 mg of hydroxyzine every 12 hours as needed. The order did not contain a date to stop the medication and was not discontinued until 05/01/25 (33 days after it was ordered). Interview with the DON on 09/04/25 at 10:05 A.M. confirmed the order for hydroxyzine to be administered on an as needed basis was active for longer than 14 days without being discontinued or re-ordered by the physician.		

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and facility policy review, this facility failed to ensure a care plan was in place for a resident diagnosis with Post-Traumatic Stress Disorder (PTSD) This affected one (Resident #3) of the one resident reviewed for accurate PTSD care planning. The facility census was 40. Findings include: Review of the medical record for Resident #3 revealed an initial admission date of 09/10/2024 and a re-entry date of 04/08/2025. Diagnoses included major depressive disorder, anxiety disorder, bipolar disorder, PTSD, and schizoaffective disorder. Review of Resident #3's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating an intact cognition for daily decision-making abilities. Resident #3 was noted to receive antianxiety, antidepressant, opioids, and anticonvulsants daily. Review of Trauma assessments completed for Resident #3 on 09/11/24, 04/08/25, and 07/15/25 verified this resident has a diagnosis of PTSD. Review of an old care plan for Resident #3 with a closed-out date of 04/15/2025 revealed a care plan that was initiated on 09/20/2024 with a resolved date of 04/08/2025 revealed Resident #3 had a history of trauma related to loss of her daughter. Resident states that some triggers can be certain songs, shows, or seeing her grandkids. Continued review of this resolved care plan revealed a revision date of 04/28/2025. Review of Resident #3's current care plan revealed no active plan related to this resident PTSD diagnosis including triggers. A care plan with the initiated date of 09/02/2025 and created by Social Worker #153 was noted to appear indicating Resident #3 has a history of trauma related to loss of her daughter, triggered by crying children, indicator of stress, and becoming withdrawn from social situations. Interview 09/03/2025 2:46 P.M. with Social Worker #153 and Regional Nurse #188 revealed Resident #3 resided at this facility for a while until she discharged and then admitted on [DATE]. Prior to this discharge, there was a care plan in place for the PTSD diagnosis. Social Worker #153 claimed the care plan that stated resolved on it was never resolved and was revised on 04/28/2025 and was in place clear up to this current date. Social Worker #153 and Regional Nurse #188 could not explain why the old care plan had a resolve date of 04/08/2025 and there was a new initiated PTSD care plan dated 09/02/2025. Review of the facility plan of care titled Care Plans, Comprehensive Person-Centered, revised 12/2016 revealed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment.		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a referral appointment was made timely with ophthalmology for Resident #11. This affected one (Resident #11) of two residents reviewed for communication and sensory. The facility census was 40. Review of the medical record for Resident #11 revealed a readmission date of 04/10/25 with diagnoses including heart failure, chronic obstructive pulmonary disorder, atrial fibrillation, diabetes mellitus type two, peripheral vascular disease, dementia and bilateral cataracts. Review of the physician orders revealed an order written on 04/11/25 for audiology, dental, vision and podiatry ancillary services per 360 as needed. An order dated 04/14/25 for artificial tears ophthalmic solution 1%, instill one drop in both eyes three times daily. Review of the quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #11 was cognitively intact with delusions and rejection of care. Resident #11 required minimal assistance to complete activities of daily living. Review of the nursing progress notes revealed a note dated 04/14/25 at 5:02 P.M. Resident #11 was seen by Optometry 360 this date. New orders were written and given to the staff. A progress note dated 05/28/25 at 3:49 P.M. revealed Resident #11 requested to be seen by Optometry 360 on this date. Resident #11 was added to the list, however, was unable to be seen due to being too soon since last visit. Review of the vision exam completed by Optometry 360 dated 04/14/25 revealed Resident #11 assessment revealed combined forms of age-related cataracts bilaterally. The cataracts were visually significant. Please schedule for cataract evaluation with ophthalmologist of facility choice. The medical record did not include evidence Resident #11 was referred or seen by Ophthalmologist as of 09/04/25. Interview on 09/04/25 at 11:45 A.M. with Social Service Designee (SSD) #153 confirmed no appointment with ophthalmologist had been made for Resident #11.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and facility policy review, this facility failed to ensure neuro checks were completed after a resident experienced a unwitnessed fall. This affected one (Resident #23) of the four residents reviewed for falls. The facility census was at 40. Findings Include: Review of the medical record for Resident #23 revealed an admission date of 08/31/2020. Diagnoses included senile degeneration of the brain, peripheral vascular disease, restlessness and agitation, and optic atrophy bilateral. Review of Resident #23's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 03 out of 15 indicating a severely impaired cognition for daily decision-making abilities. Resident #23 was noted to experience impairment to bilateral lower extremities and was dependent on staff assistance for bed mobility. Review of the plan of care dated 03/05/2022 and revised 04/15/24 revealed Resident #23 had the potential for injury or fall related to poor safety awareness, confusion, poor communication comprehension, episodes of bowel and bladder incontinence, and psychoactive drug use. Interventions include to anticipate and meet resident's needs, be sure the call light is in reach and encourage resident to use it, encourage resident to participate in activities, wear glasses when out of bed, keep bed in the lowest position with floor mat on left side, bilateral footrest on wheelchair, administer ordered medication, wear appropriate footwear, and keep commonly used items in reach. Review of the fall investigation dated 02/05/2025 at 9:21 A.M. for Resident #23 revealed, Heard resident yelling out, went to check, resident was sitting on the floor next to his bed with his back resting on the bed. Bed was in the lowest position, no injuries noted, resident alert and smiling at staff. Continued review of this document indicated this fall was not witnessed. Review of the nursing progress note dated 02/05/25 at 10:46 A.M. created by Licensed Practical Nurse (LPN) #299 revealed, Resident #23 was yelling out at staff who found resident sitting on the mat next to his bed. The bed was in the lowest position; resident was alert and smiling at staff sitting beside bed in an upright position. Power of Attorney (POA) made aware and unidentified Certified Nurse Practitioner (CNP) aware, will continue to monitor. Review of the fall detail progress note dated 02/05/2025 at 12:10 P.M. created by LPN #299 revealed the fall was not witnessed. The fall occurred in the resident's room. Vital signs were, Temperature: 96.7 degrees Fahrenheit, blood pressure was 122/76 millimeter of mercury (mmHg), oxygen saturation at 98% room air. No pain noted. Review of the progress note dated 02/05/2025 at 11:59 P.M. created by Medical Assistant (MA) #358 revealed Resident #23 was found sitting on the floor pad beside his bed. Assessment/Appearance for this incident was to continue to monitor, and Neuro checks will be started. Interview on 09/04/2025 11:40 A.M. with LPN #299, and #235 revealed that when a resident experiences an unwitnessed fall, neuro checks are required to be initiated due to being unsure if the resident hit their head or not. Interview on 09/04/2025 at 2:00 P.M. with the Director of Nursing (DON) revealed when a resident experiences an unwitnessed fall, neuro checks are completed. The DON confirmed no Neuro checks were completed for Resident #23 due to incorrect information being obtained when the fall occurred, The DON claimed she was told the fall was witnessed, but review of completed documents for this fall incident revealed the fall was unwitnessed. Interview on 09/04/2025 at 2:02 P.M. with LPN #299 verified she was the nurse on duty when Resident #23 fell. LPN #299 claimed that she was told by one of the housekeeping staff members that Resident #23 was sitting on the floor mat next to his bed smiling at her. This fall incident was unwitnessed. Review of the facility policy titled Falls-Clinical Protocol, revised 03/2018 revealed that falls should be categorized as those that occurred while trying to rise from a sitting or lying to an upright position, those that occurred while upright and attempting to ambulate; and other circumstances such as sliding out of a chair or rolling from a low bed to the floor. Falls should also be identified as witnessed or unwitnessed events.		

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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 resident record review, staff interview, and review of hospital discharge instructions, the facility failed to ensure discharge orders for medications were accurately implemented. This affected one resident (#39) out of the 16 residents whose medications were reviewed. The facility census was 40. Findings include: Record review for Resident #39 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included hypertension, diabetes mellitus, and adult failure to thrive. Review of the admission Minimum Data Set (MDS) assessment, dated 08/07/25, revealed the resident was assessed to have impaired cognition. Review of the hospital discharge medication instructions, dated 07/30/25, revealed Resident #39 was to continue taking one half of a tablet of 25 milligram (mg) metoprolol (an anti-hypertensive medication) twice a day after discharge from the hospital. Review of the physicians order, dated 07/31/25, revealed Resident #39 was ordered one whole tablet of 25 mg metoprolol to be administered twice a day while residing in the facility. Further record review for Resident #39 revealed the resident was not documented to suffer any adverse effects as a result of being administered 25 mg of metoprolol twice a day while residing in the facility. Interview with the Director of Nursing (DON) on 09/04/25 at 10:05 A.M. confirmed the hospital discharge instructions for Resident #39 were for the resident to continue taking one half of a tablet of 25 mg metoprolol (to equal 12.5 mg) twice a day but order was transcribed at the facility for one whole tablet (to equal 25 mg) twice a day. This citation represents non-compliance identified during the investigation of Complaint #2601352 and Complaint #2596195.		