STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365974	A. Building B. Wing	10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ohio Living Quaker Heights	514 West High Street Waynesville, OH 45068

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 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. (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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, physician interview, review of pharmacy delivery sheets, review of Controlled Drug Receipt/Records, and review of the facility policy, the facility failed to notify the physician when residents were not administered medications as ordered by the physician. This affected one (#75) out of the three residents reviewed for notification. The facility census was 61. Findings include: Review of the medical record for Resident #75 revealed the resident was admitted to the facility on [DATE], discharged on 08/12/25 and never returned. Diagnoses included dementia, anxiety disorder, hypo-osmolality and hyponatremia, major depressive disorder, diabetes mellitus (DM), atrial fibrillation, hypercholesterolemia, peripheral vascular disease, gastro-esophageal reflux disease, and hypothyroidism. Review of the Minimum Data Set (MDS) assessment for Resident #75, dated 08/12/25, revealed the resident was cognitively impaired and was dependent on staff for medication administration.Review of physician orders for Resident #75 dated 07/08/25 and discontinued on 08/12/25, revealed the resident was ordered Diltiazem (used to treat high blood pressure and heart rhythm disorders) extended release (ER) 180 milligrams (mg) daily in the morning, Sotalol (used to treat abnormal heart rhythms) 80 mg one half tablet (40 mg) twice daily and oxycodone (narcotic pain reliever) five mg every six hours as needed (PRN) for pain. Physician orders dated 07/19/25 and discontinued on 08/12/25, revealed the resident was ordered to receive isosorbide mononitrate (vasodilator used to treat heart conditions) ER 30 mg every morning. Physician orders dated 07/26/25 and discontinued on 08/02/25, revealed the resident was ordered metformin 500 mg daily. Review of the July 2025 medication administration record (MAR) for Resident #75 revealed the following: a) From 07/22/25 through 07/31/25, it was documented that the resident received diltiazem 180 mg daily, except for 07/28/25 (blank entry). b) From 07/24/25 through 07/31/25, it was documented that the resident received sotalol 80 mg twice daily, except for the morning dose of 07/28/25 (blank entry). c) From 07/19/25 through 07/29/25, it was documented the resident received isosorbide 30 mg daily, except for 07/28/25 (blank entry). a) On 07/26/25, 07/27/25, 07/28/25 (blank entry) and 07/29/25, the resident did not receive metformin 500 mg due to the medication being unavailable/new order. e) On the morning of 07/28/25, Lasix (anti-diuretic) 40 mg, Eliquis (anti-coagulant), Lantus (insulin) 20 units, cholecalciferol (vitamin D-3) (supplement), and lidocaine patch (pain reliever) were blank which indicated the resident was not administered the medications. There was also no documented blood sugar check (accuchecks) completed on 07/28/25 in the morning. Review of the August 2025 MAR for Resident #75 revealed the following: a) From 08/01/25 through 08/06/25, it was documented that the resident received diltiazem 180 mg daily. The MAR indicated the resident did not receive diltiazem 180 mg on 08/07/25, 08/10/25 (blank entry), 08/11/25 and 08/12/25, due to the medication not being available. b) From 08/01/25 through 08/04/25, it was documented that the resident received sotalol 80 mg twice daily. c) On 08/03/25 and 08/12/24, the MAR indicated the resident did not receive isosorbide due to medication no being available. d) From 08/09/25 through 08/11/25, the MAR was blank for oxycodone five mg, which indicated no medications were administered. Review of a progress note for Resident #75 dated 08/12/25 at 9:59 A.M., revealed the resident presented with an altered mental status (AMS) along with abnormal vital signs. The resident's pulse fluctuated between 29 and 40 beats per minute (normal 60-80), blood pressure was 130 over 97 milliliters of mercury (mmHg), oxygen saturation was 95 percent (%), and her body temperature was 97.9 Fahrenheit (F). Resident #75 was diaphoretic, complained of numbness in her right arm and hand along with three episodes of emesis. The resident was transferred to the hospital via squad. Review of the Prescription Order Status (a printed form by the facility showing the medications ordered and delivered) for Resident #75 on 10/07/25 at 2:00 P.M., revealed the resident had the following medications delivered to the facility: On 07/08/25, a quantity of 14 diltiazem 180 ER, a quantity of 14 sotalol 80 mg and a quantity of nine oxycodone five mg were delivered to the facility. On 07/14/25, a quantity of 28 oxycodone five mg were delivered. On 07/29/25, a quantity of 14 isosorbide 30 mg ER were delivered. On 08/04/25 a quantity of 14 sotalol were delivered. On 08/06/25, a quantity of 14 Diltiazem 180 mg ER were delivered and on 08/12/25, a quantity of 14 isosorbide tablets were delivered on 08/12/25. Review of a Controlled Drug Receipt/Record (Narcotic sheet) for Resident #75 75 on 10/07/25 at 2:10 P.M., revealed the facility received 28 oxycodone five mg tablets on 07/14/25. The resident was administered oxycodone on a regular basis from 07/16/25 through 08/08/25 when the card was empty. There were no additional oxycodone five mg received for Resident #75 after 08/08/25. Interview on 10/07/25 at 3:44 P.M. with the

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, the facility staff interview, and facility policy review the facility failed to provide resident with showers. This affected one (#75) out of the three residents reviewed for showers. The facility census was 61.Findings include:Review of the medical record for Resident #75 revealed she was admitted to the facility on [DATE]. Resident #75 was discharged to the hospital on [DATE] and never returned. Diagnoses included anxiety disorder, hypo-osmolality and hyponatremia, major depressive disorder, diabetes mellitus (DM), atrial fibrillation, hypercholesterolemia, peripheral vascular disease, gastro-esophageal reflux disease, and hypothyroidism. Review of the July 2025 shower/bathing sheets for Resident #75, revealed the resident was documented as only receiving a shower on 07/14/25 and 07/24/25. Resident #75 had no documented showers for August 2025. Review of the Minimum Data Set (MDS) assessment for Resident #75, dated 08/12/25, revealed her cognitive status was not assessed and the resident was dependent on staff for personal hygiene and bathing/showers. Interview with the Director of Nursing (DON) on 10/07/25 at 3:44 P.M. who stated the residents were assigned two shower/bathing days a week and more if needed or requested. The DON verified Resident #75 only received a shower on 07/14/25 and 07/24/25, and there was no documented evidence Resident #75 received any showers/bathing in August 2025. Review of the facility policy titled Bathing dated 02/04/24 revealed the purpose of the bathing policy was to ensure residents receive bathing and given choices if desired. Further review of the policy revealed the residents were scheduled for bathing two times per week.This deficiency represents non-compliance investigated under Complaint Number 2625070.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, physician interview, review of pharmacy delivery sheets, review of Controlled Drug Receipt/Records, and review of the facility policy, the facility failed to ensure residents were free of significant medication errors. This affected one (#75) of the three residents reviewed for medications. The census was 57. Findings include: Review of the medical record for Resident #75 revealed the resident was admitted to the facility on [DATE], discharged on 08/12/25 and never returned. Diagnoses included dementia, anxiety disorder, hypo-osmolality and hyponatremia, major depressive disorder, diabetes mellitus (DM), atrial fibrillation, hypercholesterolemia, peripheral vascular disease, gastro-esophageal reflux disease, and hypothyroidism. Review of the Minimum Data Set (MDS) assessment for Resident #75, dated 08/12/25, revealed the resident was cognitively impaired and was dependent on staff for medication administration.Review of physician orders for Resident #75 dated 07/08/25 and discontinued on 08/12/25, revealed the resident was ordered Diltiazem (used to treat high blood pressure and heart rhythm disorders) extended release (ER) 180 milligrams (mg) daily in the morning, Sotalol (used to treat abnormal heart rhythms) 80 mg one half tablet (40 mg) twice daily and oxycodone (narcotic pain reliever) five mg every six hours as needed (PRN) for pain. Physician orders dated 07/19/25 and discontinued on 08/12/25, revealed the resident was ordered to receive isosorbide mononitrate (vasodilator used to treat heart conditions) ER 30 mg every morning. Physician orders dated 07/26/25 and discontinued on 08/02/25, revealed the resident was ordered metformin 500 mg daily. Review of the progress notes for Resident #75 from 07/22/25 through 08/11/25, revealed no documentation of the physician being notified of the medication discrepancies. Review of the July 2025 medication administration record (MAR) for Resident #75 revealed the following: a) From 07/22/25 through 07/31/25, it was documented that the resident received diltiazem 180 mg daily, except for 07/28/25 (blank entry). b) From 07/24/25 through 07/31/25, it was documented that the resident received sotalol 80 mg twice daily, except for the morning dose of 07/28/25 (blank entry). c) From 07/19/25 through 07/29/25, it was documented the resident received isosorbide 30 mg daily, except for 07/28/25 (blank entry). d) On 07/26/25, 07/27/25, 07/28/25 (blank entry) and 07/29/25, the resident did not receive metformin 500 mg due to the medication being unavailable/new order. e) On the morning of 07/28/25, Lasix (anti-diuretic) 40 mg, Eliquis (anti-coagulant), Lantus (insulin) 20 units, cholecalciferol (vitamin D-3) (supplement), and lidocaine patch (pain reliever) were blank which indicated the resident was not administered the medications. 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The resident's pulse fluctuated between 29 and 40 beats per minute (normal 60-80), blood pressure was 130 over 97 milliliters of mercury (mmHg), oxygen saturation was 95 percent (%), and her body temperature was 97.9 Fahrenheit (F). Resident #75 was diaphoretic, complained of numbness in her right arm and hand along with three episodes of emesis. The resident was transferred to the hospital via squad. Review of the Prescription Order Status (a printed form by the facility showing the medications ordered and delivered) for Resident #75 on 10/07/25 at 2:00 P.M., revealed the resident had the following medications delivered to the facility: On 07/08/25, a quantity of 14 diltiazem 180 ER, a quantity of 14 sotalol 80 mg and a quantity of nine oxycodone five mg were delivered to the facility. On 07/14/25, a quantity of 28 oxycodone five mg were delivered. On 07/29/25, a quantity of 14 isosorbide 30 mg ER were delivered. On 08/04/25 a quantity of 14 sotalol were delivered. 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