STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365987	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calcutta Health Care Center	48444 Bell School Road Calcutta, OH 43920

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and review of facility policy the facility failed to ensure the physician was thoroughly informed and timely notified of a change of condition for Resident #98 in order to identify and authorize proper treatment. This affected one resident (#98) of six residents reviewed for change of condition. The facility census was 97. Findings include: Review of the closed medical record for Resident #98 revealed an admission date of 11/17/25 with diagnoses including but not limited to weakness, difficulty walking, oral phase dysphagia, muscle wasting, protein-calorie malnutrition, pneumonitis due to inhalation of food and vomit, asthma, cardiac implant and viral meningitis. Resident #98 was emergency transferred from the facility to the hospital emergency room on [DATE] and expired in the hospital on [DATE].Review of physician orders dated 11/17/25 revealed Resident #98 had a Do Not Resuscitate Comfort Care Arrest (DNRCC-A) order indicating standard care and life extending measures would to be used right up until the point of cardiac or respiratory arrest.Review of the admission assessment dated [DATE] at 5:01 P.M. written by Licensed Practical Nurse (LPN) #400 revealed Resident #98 was admitted to the facility from a general hospital. Lifestyle prior to admission was semi-dependent, she used a walker to ambulate and needed some help with activities. Resident #98's diet consistency was mechanical soft, ground meat with thin liquids. Resident #98 was alert to person, place, time and situation. No cough was present, lung sounds were clear, no rhonchi (thick mucus in airway) , and no wheezes. Pulse was equal, bowel sounds present, soft abdomen, and continent of bladder. There was moderate pain in the right hip, and she used a walker for mobility. Resident #98 was pleasant, and cooperative.Review of the care plan date initiated 11/18/25 for Resident #98 revealed a risk for bruising/bleeding due to antiplatelet therapy related to prophylactic. Interventions included medications per physician order, monitor and report abnormal results to physician and monitor for side effects or adverse reaction of medications and report to physician. Monitor, document, and report as needed to physician any signs or symptoms of abnormal bleeding, bruising, black tarry stools, discolored urine, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, sudden changes in mental status, nose bleeds. Shortness of breath and hypotension. Finally, vital signs per order, document and report any significant abnormalities to physician.Review of the care plan date initiated 11/18/25 for Resident #98 revealed a risk for impaired air exchange due to asthma and aspiration pneumonia. Interventions included maintain saturations of oxygen greater than 88 percent, monitor for increased shortness of breath, cyanosis, increased edema, pallor or respiratory distress, administer medication per physician orders and monitor or adverse reactions, head of bed elevated.Review of Resident #98's Treatment Administration Record dated November 2025, revealed Resident 98's vitals were taken once during the night on 11/22/25.Review of the vital records in the electronic medical record revealed vitals were recorded on 11/22/25 at 11:27 P.M. by LPN #619 that included a blood pressure reading of 153/84 mm/Hg, temperature 98 degrees Fahrenheit (F), pulse rate 88 beats per minute (bpm), respiration 18 breaths per minute, and oxygen saturation 94 percent room air. Review of the Medicare Five Day Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #98's Brief (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
	365987	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calcutta Health Care Center	48444 Bell School Road Calcutta, OH 43920

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	Interview for Mental Status (BIMS) score was 13 out of 15 indicating intact cognition. No indicator of psychosis, behavior symptoms and no rejection of care was present. Resident #98 needed supervision to eat and maximal assistance for bathing. Moderate assistance was needed to transfer from bed to chair and to walk ten feet. Resident #98 had shortness of breath with exertion, while sitting and lying flat. Resident #98 did not have a chronic disease that would result in a life expectancy of less than six months. Problem conditions included vomiting and internal bleeding. Resident #98 had coughing or choking during meals or when swallowing medication and complained of difficulty or pain when swallowing. Resident #98 needed a mechanically altered diet that required a change in texture of food.Review of a nursing progress note dated 11/23/25 at 1:40 A.M. authored by LPN #619 documented Resident #98 had an episode of dark watery emesis. No other assessment of the resident was included at this time. The note included the daughter/POA was notified and did not want to send resident to the emergency room (ER) at this time. There was no documentation in the note to indicate the physician had been notified. Review of the resident's progress notes revealed no additional assessments, documentation of monitoring or notes after the note at 1:40 A.M. until the note authored by LPN #619 at 7:20 A.M.Review of Resident #98's Medication Administration Record (MAR), dated 11/23/25, revealed Resident #98 received the following mediation at Rise time by LPN #619 : Aspirin tablet chewable 81 milligrams (mg) by mouth, calcium citrate- Vitamin D oral tablet 200-6.25 milligrams (mg) one tablet by mouth, Cholecalciferol tablet 1000 unit two tablets by mouth, Glycolax powder 17 grams by mouth , levothyroxine 100 microgram (mcg) by mouth at 6:00 A.M., Metoprolol tablet 50 mg one tablet by mouth, multivitamin one tablet by mouth, Protonix 40 mg one tablet by mouth, Tropism chloride oral capsule 60 mg by mouth., Reglan 5 mg one tablet by mouth, and Sennoside tablet 8.6 mg by mouth.Review of the facility document titled Medication Pass, undated, revealed Rise medication pass was between the hours of 5:00 A.M. to 10:00 A.M.Review of the nursing progress note dated 11/23/25 at 7:20 A.M. authored by LPN #619 revealed Resident #98's daughter was notified of resident having more episodes of dark emesis this shift. The nurse documented the daughter wanted to wait to see what the doctor (Primary Care Physician (PCP) #701) wanted to do.Review of the nursing progress note dated 11/23/25 at 7:49 A.M. authored by LPN #619 revealed Resident #98 had more episodes of dark emesis this shift. There was no documentation of any type of assessment including vital sign monitoring of the resident at this time. PCP #701 was notified and a new order for a complete blood count (CBC) this morning and daughter (POA) notified.Review of Resident #98's Treatment Administration Record dated November 2025 revealed Resident 98's vital signs were taken once during the day on 11/23/25. Review of the vital records in the electronic medical record revealed on 11/23/25 at 8:42 A.M. LPN #518 documented the resident's vital signs included an oxygen saturation of 67 percent on room air, respiration rate of 40 breaths per minute (elevated), pulse rate 109 bpm (elevated/tachycardic), temperature 97.9 degrees (F), and blood pressure 88/92 mmHg (hypotensive).Review of the nursing progress note dated 11/23/25 at 8:44 A.M. authored by LPN #518 revealed she was in Resident #98's room to assess following an emesis. Upon assessment this nurse observed resident to have a dark brown/black emesis. Resident #98 did not respond to LPN #518 per baseline. Vitals were obtained that included a blood pressure 88/52 very faint, pulse 109, respirations 40, temperature 97.9 Fahrenheit (F) and oxygen (saturation) 67 percent. The note indicated supplemental oxygen was applied. Resident #98 did not respond via nasal cannula simple mask. Fifteen liters nonrebreather oxygen applied and oxygen went to 80 percent. Resident #98 still did not respond appropriately or open eyes. Abdomen was soft and non-tender. The note included the resident's daughter (POA) wanted the resident sent to Emergency Room. Ambulance contacted and made aware of need for transport. Hospital emergency room nurse to nurse given.Review of the Situation, Background, Assessment, Recommendation (SBAR) assessment form dated 11/23/25 at 8:44 A.M. authored by LPN #518 revealed a change in condition evaluation was done due to abnormal vital signs, altered mental status, functional decline, nausea or vomiting, shortness of breath, unresponsiveness, seems different than usual and confused at the time 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
	365987	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calcutta Health Care Center	48444 Bell School Road Calcutta, OH 43920

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	evaluation. The SBAR included the resident's blood pressure was 88/52 lying down, pulse 109, respirations 40, pulse oximetry 67 percent room air. Code status DNRCC-A. Nursing observation included brown/black emesis. Resident not responding per baseline, confusion noted. Resident not opening eyes, mumbling. Vitals obtained, supplemental oxygen applied, physician notified, daughter (POA) notified. Sent to (ER) for evaluation for and treatment. PCP #701 responded with the following recommendations: send to ER.Interview on 03/25/26 at 8:58 A.M. with Resident #98's daughter/Power of Attorney (POA) revealed the last time she saw her mother was on 11/21/25 during dinner time and there were no concerns with her mother's health at that time. The POA stated on 11/23/25 around 2:00 A.M. she received a phone call from LPN #619. The POA revealed LPN #619 told her Resident #98 was spitting up a little bit and asked if the POA wanted to send Resident #98 to the hospital. The POA stated she said yes if the nurse felt it was needed. The POA asked how much spit up and LPN #619 stated the spit up was a little bit and also stated the doctor would be in soon and to wait to see what the doctor thought. The POA stated she agreed to let the doctor look at her mother. The POA stated she received a second phone call around 7:00 A.M. on 11/23/25 from a different nurse stating her mother was in a bad condition and an ambulance was called. The POA stated when Resident #98 was in the emergency room she was told her mother had pneumonia, had aspirated and a possible bleed because of the coffee ground blood signs were in her mouth. The hospital gave her the option of placing Resident #98 on a ventilator to explore the source of the bleed or Hospice care. The POA stated she chose hospice care and Resident #98 passed away the next day in the hospital.Interview on 03/25/26 at 4:19 P.M. with LPN #518 revealed she worked day shift 11/23/25 and during report the outgoing nurse (LPN #619) reported Resident #98 was under the weather overnight, and she had called the POA who did not want to send Resident #98 to the hospital. The outgoing nurse (LPN #619) stated Resident #98 was stable at the time of report. LPN #518 stated she attended to two other residents and then was called to Resident #98's room because the lab tech could not draw blood from Resident #98. LPN #518 stated she stepped out of Resident #98's room to go to the medication cart and was notified Resident #98 was less responsive. LPN #518 obtained vitals and observed dark brown emesis on Resident #98. LPN #518 call the POA, physician and the ambulance. LPN #518 stated she did not pass medication to Resident #98 that morning, the outgoing nurse (LPN #619) had already administered the RISE medication pass to Resident #98 prior to ending her shift.Interview on 03/25/26 at 5:29 P.M. with the Director of Nursing(DON) revealed it was standard nursing practice to notify the physician if aspiration was suspected and vitals could be done more often than once a shift if the physician requested. The DON stated the night nurse (LPN #619) made the POA aware but not the physician because the POA did not want resident sent to the hospital; therefore, the nurse did not call the physician.Interview on 03/25/26 at 5:45 P.M. with LPN #619 verified she worked the night of 11/23/25 and stated Resident #98 had emesis that night but the POA did not want to send Resident #98 to the hospital. LPN #619 stated she observed the emesis to be a little dark brown but stated the emesis was enough Resident #98 needed her gown changed. LPN #619 verified she did not take additional vital signs that night and her intervention was to keep an eye on her. LPN #619 verified she did not call the physician after the brown emesis and revealed the resident had three to four emesis during the night to which she did not contact the physician. LPN #619 revealed she sent the PCP a text around 7:00 A.M. LPN #619 verified she passed medication to Resident #98 for the RISE medication pass time that could have been around 5:00 A.M. to 6:00 A.M. (unable to recall exact time). LPN #619 stated she provided Resident #98 fluids through the night but did not assess if her oral cavity was clear. LPN #619 verified vital sign monitoring should be done immediately with a change in condition and physician should be notified. LPN #619 stated she did not have concerns when speaking with the POA around 2:00 A.M. on 11/23/25 and suggested to wait until the physician was in the facility later that morning to see the resident. LPN #619 verified she did not call the POA again regarding the continued episodes of brown emesis that were significant enough to require gown changes.Interview on 03/26/26 at 1:58 P.M. with the DON revealed an investigation was (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365987	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calcutta Health Care Center	48444 Bell School Road Calcutta, OH 43920

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	not done related to Resident #98's change in condition and subsequent hospitalization. The DON verified LPN #619 did not document if or how many times the POA was called during the night. The DON verified the RISE medication was passed to Resident #98 during the morning of 11/23/25. The DON stated standard nursing practice was to call the physician if a resident had emesis and verified LPN #619 did not call the physician and additional vital sign monitoring or assessment were not completed or documented. The DON also verified no documentation existed regarding the times of emesis during the night or if the POA was additionally called.Interview on 03/26/26 at 3:13 P.M. with Medical Director #702 revealed it was the expectation of the facility to notify the physician any time of day or night if a resident had an acute change in condition. Medical Director #702 stated if the situation was critical the resident was to be sent to the ER and the physician and family called, and three or four brown/black emesis would be considered critical.Interview on 03/26/26 at 4:30 P.M. with Resident #98's PCP, PCP #701 revealed he received a text early in the morning on 11/23/25 and was not notified again until later in the morning around 7:00 A.M. by text that Resident #98 had brown like emesis. He stated an order for a CBC lab draw was made. PCP #701 stated it was his understanding the POA did not want the resident sent out to the hospital.Interview on 03/31/26 at 2:36 P.M. with CNA #704 revealed she worked the night shift on 11/22/25. CNA #704 reported she notified LPN #619 that Resident #98 had episodes of brown, mucus-like emesis and the resident needed gown changes. CNA #704 stated Resident #98 had approximately six episodes of emesis during the shift, including one large episode requiring a full bed change and CNA placed a towel by the resident's mouth.Review of the facility policy titled Acute Condition Changes Clinical Protocol, revised December 2015, revealed the nurse shall document and report vital signs, neurological status, pain, consciousness, onset duration and severity. Before contacting a physician about someone with an acute change of condition, the nursing staff would make detailed observations and collect pertinent information to report to the physician. The attending physician or practitioner providing back up coverage would respond in a timely manner (half hour or less) to notification of problems or changes in condition or status. The staff would notify the medical director for additional guidance or consultation if they did not receive a timely or appropriate response. The nurse and physician would discuss and evaluate the situation. The physician should ask questions to clarify the situation, for example, vitals signs, physical findings, and symptoms description. The physician would discuss with staff and/or resident families the benefits and risks of diagnosing and managing the situation in the facility versus the hospital. The physician would identify and authorize proper treatment. The staff would monitor and document responses to treatment and the physician will adjust treatment accordingly until the problem has been resolved or stabilized.This deficiency represents noncompliance investigated under Complaint Number 2769707.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365987	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calcutta Health Care Center	48444 Bell School Road Calcutta, OH 43920

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, review of the ambulance run report, review of hospital records, review of death certificate, interviews with staff, physicians and resident power of attorney (POA), and review of facility policies, the facility failed to provide adequate monitoring and timely identification of an acute change in condition to prevent a delay in treatment for Resident #98. This resulted in Immediate Jeopardy and Actual Harm (subsequent death) beginning on 11/23/25 at approximately 1:40 A.M. when Resident #98, who had a known history of oral phase dysphagia, pneumonitis due to inhalation of food and vomit, use of antiplatelet therapy and was care planned for aspiration risk, and bleeding risk related to antiplatelet therapy, began to have brown emesis which continued throughout the midnight shift without proper assessment by the assigned nurse who proceeded to administer medications (on 11/23/25 RISE) via oral route without evidence of checking the oral cavity, completing a physical assessment, assessing the resident's vital signs or updating the physician of the ongoing emesis. On 11/23/25 at 8:44 A.M. Resident #98 was poorly responsive and was in respiratory distress requiring emergency transfer to the hospital where she was diagnosed with pneumonia, aspiration and gastrointestinal bleed. Subsequently Resident #98 was in need of mechanical ventilation and invasive testing to rule out the source of the bleed. However, the resident's family elected for Hospice care at this time and the resident expired on 11/24/25. The facility failure to implement appropriate monitoring and assessment, and failure to timely identify and treat an acute change in condition affected one resident (#98) of six residents reviewed for quality of care. The facility census was 97. On 03/30/26 at 11:54 A.M. the Administrator, Director of Nursing (DON), and Administrator in Training (AIT) #703 were notified Immediate Jeopardy began on 11/23/25 when Resident #98 was found in her room following an acute change in condition that resulted severe respiratory distress and emergency transfer to the hospital where she later expired on 11/24/25. The facility failed to ensure appropriate monitoring and assessment of the resident and failed to timely identify and treat an acute change in condition resulting in Resident #98's death. The Immediate Jeopardy was removed on 03/31/26 when the facility implemented the following corrective actions:On 3/30/26 the Director of Nursing (DON) contacted the Medical Director to inform him of the Immediate Jeopardy details involving Resident #98. The facility Quality Assurance Performance Improvement (QAPI) team and corporate staff met which included Corporate Registered Nurse (RN) #809, #900 and #901 and facility staff including the Director of Nursing (DON), Wound RN, RN Unit Manager, LPN Unit Manager, RN MDS/SS #902, RN MDS #903, RN/MDS #904, the Administrator, Social Services (SS), Activity Director, Dietary Director (DT). The discussion focused on review of the medical record for Resident #98 and collaboration on immediate educational materials and intervention to re-educate staff and assist administration in alternate ways to monitor documentation and the timely identification, intervention, assessment, documentation and notification of physician and family for any changes in a resident's condition. On 03/30/2026 the Administrator and Corporate RNs #809, #900 and #901 reviewed the facility Change in a Resident's Condition and the Acute Condition Changes policies the facility had in place and began re-educating all facility nurses and certified nursing assistants in-person. Additional in-person education included the following which was completed by 03/31/26: Education regarding proper timely identification of adequate interventions for and documentation of an identified change in condition.Education regarding proper timely notification of the physician and family of a change in condition and that accurate information is provided.Education regarding Certified Nursing Assistant (CNA) notification to nurse of concern in a residents change in condition. If the CNA feels the nurse the CNA reported to has not responded, the CNA should report the concerns to the supervisor or administration immediately.Education regarding physician notification of all changes in condition. If the primary care physician, or their on-call staff do not respond, the facility Medical Director should be called to report the change in condition.Education (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365987	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calcutta Health Care Center	48444 Bell School Road Calcutta, OH 43920

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to nurses regarding reporting any concerns or possible concerns (i.e. emesis, new pain, change in mental status, new decrease in physical functioning, fever, cough, etc.) to the facility supervisor for assistance in ensuring staff is identifying, documenting, intervening and reporting changes in resident condition.The education identified above would also be included in the orientation packet for review with all new nurses and CNA staff effective 04/01/2026. On 03/30/2026 Corporate RNs #809, #900 and #901 re-educated administrative staff including the Administrator, DON, RN Unit Manager and LPN Unit Manager on reviewing the 24 hour/72 hour summary (summary of nursing notes) and other ways to monitor nurses' notes, changes in condition, discharges to the hospital, etc. The Administrator would now begin reading these summaries as well. On 03/30/2026, Corporate RN #809 and #900 completed record reviews of all residents sent to the hospital since 03/01/2026 to review for concerns related to identification, documentation and notification of changes in condition.On 3/30/2026 the facility administrative nurses (DON, RN Unit Manager, LPN Unit Manager) conducted nursing assessments (consisting of assessing residents head to toe, including vitals, lung sounds, bowel sounds and if any complaints noted) on all current residents to assess for any indications of a change in condition. Alert and oriented residents (those with a Brief Interview for Mental Status (BIMS) score of 10 or above) were asked during these assessments if they felt as though they have had a recent change in condition. Those residents who were not alert and oriented, the emergency contact/POA was contacted to review the assessments and asked if they felt as though the resident has had a recent change in condition. These assessments and responses from the resident and/or emergency contact/POA were documented in each resident's medical record in progress notes by the end of the day on 03/30/2026. Staff also reviewed with the emergency contact/POA, that when a change in condition was identified, the facility protocol was to contact the physician, then the emergency contact/POA. This was completed on 03/30/26, except for two residents on leave of absence which were completed on 03/31/26. For on-going monitoring, beginning on 03/30/26 the Administrator divided the facility into four sections and began the following: The Administrator, the DON, RN Unit Manager and LPN Unit Manager were assigned one of those four sections. Each would be responsible to read the 24-72-hour summary each morning for the assigned section of the facility. They will review these for any indications of a change in condition and how it was handled and documented. The Administrator, DON, RN Unit Manager and LPN Unit Manager would then meet after morning meeting to discuss any areas of concern. Any residents who were sent to the hospital would have a medical record review completed and the team would discuss any issues or concerns. This would be on-going. The facility QAPI team would then reassess the frequency of the morning meetings with the Administrator, DON and unit managers. For ongoing monitoring, beginning on 04/01/26, the Administrator, DON, RN Unit Manager and LPN Unit Manager would conduct chart reviews for three to four high risk residents daily for two weeks, then weekly for four weeks, then monthly for three months. The findings of the high-risk audits would be discussed with the QAPI team monthly. The QAPI team would discuss the findings and make any recommendations concerning the findings or need to adjust the frequency or extend the initially planned time frames for the audits. This will continue for at least three months, through 07/01/26. The summary reviews, high risk charts audited and morning meeting will be documented on forms for record of audits. Although the Immediate Jeopardy was removed on 03/31/26 the deficiency remains at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include:Review of the closed medical record for Resident #98 revealed an admission date of 11/17/25 with diagnoses including but not limited to weakness, difficulty walking, oral phase dysphagia, muscle wasting, protein-calorie malnutrition, atherosclerotic heart disease, gastroesophageal reflux disease, pneumonitis due to inhalation of food and vomit, asthma, cardiac implant and viral meningitis. Resident #98 was emergency transferred from the facility to the hospital emergency room on [DATE] and expired in the hospital on [DATE]. Review of physician orders dated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365987	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calcutta Health Care Center	48444 Bell School Road Calcutta, OH 43920

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	11/17/25 revealed Resident #98 had a Do Not Resuscitate Comfort Care Arrest (DNRCC-A) order indicating standard care and life extending measures would to be used right up until the point of cardiac or respiratory arrest. Resident #98 was ordered vital signs every shift. Review of the admission assessment dated [DATE] at 5:01 P.M. authored by Licensed Practical Nurse (LPN) #400 revealed Resident #98 was admitted to the facility from a general hospital. Lifestyle prior to admission was semi-dependent, she used a walker to ambulate and needed some help with activities. Resident #98's diet consistency was mechanical soft, ground meat with thin liquids. Resident #98 was alert to person, place, time and situation. No cough was present, lung sounds were clear, no rhonchi (thick mucus in airway), and no wheezes. Pulse was equal, bowel sounds present, soft abdomen, and continent of bladder. The assessment noted the resident had moderate pain in the right hip, and she used a walker for mobility. Resident #98 was pleasant, and cooperative.Review of a physician order dated 11/18/25 revealed to start Aspirin tablet chewable 81 milligrams (mg) by mouth in the morning (prophylactic) related to atherosclerotic heart disease.Review of the care plan date initiated 11/18/25 revealed Resident #98 was at risk for bruising/bleeding due to (prophylactic) antiplatelet therapy. Interventions included medications per physician order, monitor and report abnormal results to physician and monitor for side effects or adverse reaction of medications and report to physician. Monitor, document, and report as needed to physician any signs or symptoms of abnormal bleeding, bruising, black tarry stools, discolored urine, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, sudden changes in mental status, nose bleeds. Shortness of breath and hypotension. The care plan also included vital signs per order, document and report any significant abnormalities to physician.Review of the care plan date initiated 11/18/25 revealed Resident #98 was at risk for impaired air exchange due to asthma and aspiration pneumonia. Interventions included maintain saturations of oxygen greater than 88 percent, monitor for increased shortness of breath, cyanosis, increased edema, pallor or respiratory distress, administer medication per physician orders and monitor or adverse reactions, head of bed elevated.Review of the Physician Note dated 11/19/25 at 3:54 P.M. written by the Primary Care Physician (PCP) #701 revealed Resident #98 presented to the facility for therapy from the hospital (name provided). On examination Resident #98 was resting in bed, reported feeling sore and had occasional shortness of breath with scant phlegm production. She denied nausea and vomiting. Physical exam revealed lungs without wheeze, rales or rhonchi (rattling caused by fluid obstructing the airway). The plan was to continue occupational therapy and physical therapy, continue antibiotic for viral meningitis, continue aspirin for coronary artery disease and Protonix and Reglan for gastroesophageal reflux disease.Review of Resident #98's Treatment Administration Record dated November 2025, revealed Resident 98's vitals were taken once during the night on 11/22/25.Review of the vital records in the electronic medical record revealed vitals were recorded on 11/22/25 at 11:27 P.M. by LPN #619 that included a blood pressure reading of 153/84 mm/Hg, temperature 98 degrees Fahrenheit (F), pulse rate 88 beats per minute (bpm), respiration 18 breaths per minute, and oxygen saturation 94 percent room air. Review of the Medicare Five Day Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #98's Brief Interview for Mental Status (BIMS) score was 13 out of 15 indicating intact cognition. No indicator of psychosis, behavior symptoms and no rejection of care was present. The assessment revealed Resident #98 needed (staff) supervision to eat and maximal (staff) assistance for bathing. Moderate (staff) assistance was needed to transfer from bed to chair and to walk ten feet. Resident #98 had shortness of breath with exertion, while sitting and lying flat. Resident #98 did not have a chronic disease that would result in a life expectancy of less than six months. Problem conditions included vomiting and internal bleeding. Resident #98 had coughing or choking during meals or when swallowing medication and complained of difficulty or pain when swallowing. Resident #98 needed a mechanically altered diet that required a change in texture of food. Resident #98 had broken and loose fitting dentures and had discomfort when chewing. The assessment also noted Resident #98 received antiplatelet drug therapy.Review of a nursing progress note dated 11/23/25 at 1:40 A.M. authored by (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365987	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calcutta Health Care Center	48444 Bell School Road Calcutta, OH 43920

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	LPN #619 documented Resident #98 had an episode of dark watery emesis. No other assessment of the resident was included at this time. The note included the daughter/POA was notified and did not want to send resident to the emergency room (ER) at this time.Review of the resident's progress notes revealed no additional assessments, documentation of monitoring or notes after the note at 1:40 A.M. until the note authored by LPN #619 at 7:20 A.M.Review of Resident #98's Medication Administration Record (MAR), dated 11/23/25 revealed Resident #98 received the following mediation at Rise time by LPN #619 : Aspirin tablet chewable 81 milligrams (mg) by mouth, calcium citrate-Vitamin D oral tablet 200-6.25 milligrams (mg) one tablet by mouth, Cholecalciferol tablet 1000 unit two tablets by mouth, Glycolax powder 17 grams by mouth , levothyroxine 100 microgram (mcg) by mouth at 6:00 A.M., Metoprolol tablet 50 mg one tablet by mouth, multivitamin one tablet by mouth, Protonix 40 mg one tablet by mouth, Trospium chloride oral capsule 60 mg by mouth, Reglan 5 mg one tablet by mouth, and Sennoside tablet 8.6 mg by mouth.Review of the facility undated document titled Medication Pass revealed Rise medication pass was scheduled between the hours of 5:00 A.M. to 10:00 A.M.Review of the nursing progress note dated 11/23/25 at 7:20 A.M. authored by LPN #619 revealed Resident #98's daughter was notified of resident having more episodes of dark emesis this shift. The nurse documented the daughter wanted to wait to see what the doctor (Primary Care Physician (PCP) #701) wanted to do.Review of the nursing progress note dated 11/23/25 at 7:49 A.M. authored by LPN #619 revealed Resident #98 had more episodes of dark emesis this shift. There was no documentation of any type of assessment including vital sign monitoring of the resident at this time. PCP #701 was notified and a new order for a complete blood count (CBC) this morning and daughter (POA) notified.Review of Resident #98's Treatment Administration Record dated November 2025 revealed Resident 98's vital signs were taken once during the day on 11/23/25. Review of the vital records in the electronic medical record revealed on 11/23/25 at 8:42 A.M. LPN #518 documented the resident's vital signs included an oxygen saturation of 67 percent on room air, respiration rate of 40 breaths per minute (elevated), pulse rate 109 bpm (elevated/tachycardic), temperature 97.9 degrees (F), and blood pressure 88/92 mmHg (hypotensive). Review of the nursing progress note dated 11/23/25 at 8:44 A.M. authored by LPN #518 revealed she was in Resident #98's room to assess following an emesis. Upon assessment this nurse observed resident to have a dark brown/black emesis. Resident #98 did not respond to LPN #518 per baseline. Vitals were obtained that included a blood pressure 88/52 very faint, pulse 109, respirations 40, temperature 97.9 Fahrenheit (F) and oxygen (saturation) 67 percent. The note indicated supplemental oxygen was applied. Resident #98 did not respond via nasal cannula simple mask. Fifteen liters nonrebreather oxygen applied and oxygen went to 80 percent. Resident #98 still did not respond appropriately or open eyes. Abdomen was soft and non-tender. The note included the resident's daughter (POA) wanted the resident sent to Emergency Room. Ambulance contacted and made aware of need for transport. Hospital emergency room nurse to nurse given. Review of the Situation, Background, Assessment, Recommendation (SBAR) assessment form dated 11/23/25 at 8:44 A.M. authored by LPN #518 revealed a change in condition evaluation was done due to abnormal vital signs, altered mental status, functional decline, nausea or vomiting, shortness of breath, unresponsiveness, seems different than usual and confused at the time of evaluation. The SBAR included the resident's blood pressure was 88/52 lying down, pulse 109, respirations 40, pulse oximetry 67 percent room air. Code status DNRCC-A. Nursing observation included brown/black emesis. Resident not responding per baseline, confusion noted. Resident not opening eyes, mumbling. Vitals obtained, supplemental oxygen applied, physician notified, daughter (POA) notified. Sent to (ER) for evaluation for and treatment. PCP #701 responded with the following recommendations: send to ER.Review of the ambulance (name provided) Run Report dated 11/23/25 revealed a call came in to dispatch on 11/23/25 at 8:45 A.M. for Resident #98 who was short of breath with a pulse ox (oxygen) in the 60s. Emergency responders were dispatched to the facility, arriving onsite at 8:55 A.M. and to the resident at 8:55 A.M. Upon arrival, the resident was found in her room with nursing staff at bedside. Per nursing staff patient had (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365987	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calcutta Health Care Center	48444 Bell School Road Calcutta, OH 43920

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	multiple episodes of vomiting last night that was dark in color. Resident had a rapid decline on nursing staff and was on 15 liters oxygen with pulse ox of 82 percent. Resident complained of shortness of breath and had diminished lung sound to the right lower lobes. Resident also complained of right rib pain. A three lead (EKG) was placed prior to moving resident which showed sinus arrythmia with premature ventricular contractions (PVC) which are early heart beats disrupting the hearts normal rhythm). Resident #98 arrived to the emergency room at 9:26 A.M. Review of Hospital Emergency Department Report dated 11/23/25 at 9:36 A.M. revealed Resident #98 was sent to the emergency room (ER) for shortness of breath and low pulse ox at the nursing home. It was reported that Resident #98's pulse ox was 66 percent at the nursing home. It was reported Resident #98 was vomiting brown substance off and on all night. Resident #98 had a history of remote gastrointestinal bleed according to the family. Physical exam of head, eyes, ears, nose and throat revealed there was brown substance coating the resident's mouth and around the lips. Physical exam of the lungs revealed rales (crackles) apparent in the right lung upper and lower lobes. Differential diagnosis included pneumonia, aspiration and gastrointestinal (GI) bleed. Chest x-ray revealed infiltrate in the right upper and lower lobes consistent with pneumonia possible aspiration. Daughter was updated and Hospice was suggested due to sepsis criteria. Resident #98 was admitted to the hospital on [DATE] for critical care. On 11/24/26 Resident #98 transitioned to the care of Hospice for palliative care and Resident #98 expired on 11/24/25 at 2:58 P.M.Review of the nursing progress note dated 11/23/25 at 3:02 P.M. authored by LPN #518 revealed the hospital was contacted for an update. The ER nurse stated Resident #98 was admitted with diagnosis of gastrointestinal bleed, aspiration pneumonia and severe sepsis.Review of Ohio Department of Health Vital Statistics Certificate of Death dated 11/24/25 revealed Resident #98 place of death was inpatient hospital, immediate cause of death was severe sepsis and bilateral aspiration pneumonia on 11/24/25. Interview on 03/25/26 at 8:58 A.M. with Resident #98's daughter/Power of Attorney (POA) revealed the last time she saw her mother was on 11/21/25 during dinner time and there were no concerns with her mother's health at that time. The POA stated on 11/23/25 around 2:00 A.M. she received a phone call from LPN #619. The POA revealed LPN #619 told her Resident #98 was spitting up a little bit and asked if the POA wanted to send Resident #98 to the hospital. The POA stated she said yes if the nurse felt it was needed. The POA asked how much spit up and LPN #619 stated the spit up was a little bit and also stated the doctor would be in soon and to wait to see what the doctor thought. The POA stated she agreed to let the doctor look at her mother. The POA stated she received a second phone call around 7:00 A.M. on 11/23/25 from a different nurse stating her mother was in a bad condition and an ambulance was called. The POA stated when Resident #98 was in the emergency room she was told her mother had pneumonia, had aspirated and a possible bleed because of the coffee ground blood signs were in her mouth. The hospital gave her the option of placing Resident #98 on a ventilator to explore the source of the bleed or Hospice care. The POA stated she chose hospice care and Resident #98 passed away the next day in the hospital. Interview on 03/25/26 at 4:19 P.M. with LPN #518 revealed she worked day shift 11/23/25 and during report the outgoing nurse (LPN #619) reported Resident #98 was under the weather overnight, and she had called the POA who did not want to send Resident #98 to the hospital. The outgoing nurse (LPN #619) stated Resident #98 was stable at the time of report. LPN #518 stated she attended to two other residents and then was called to Resident #98's room because the lab tech could not draw blood from Resident #98. LPN #518 stated she stepped out of Resident #98's room to go to the medication cart and was notified Resident #98 was less responsive. LPN #518 obtained vitals and observed dark brown emesis on Resident #98. LPN #518 call the POA, physician and the ambulance. LPN #518 stated she did not pass medication to Resident #98 that morning, the outgoing nurse (LPN #619) had already administered the RISE medication pass to Resident #98 prior to ending her shift.Interview on 03/25/26 at 5:29 P.M. with the Director of Nursing(DON) revealed it was standard nursing practice to notify the physician if aspiration was suspected and vitals could be done more often than once a shift if the physician requested. The DON stated the night nurse (LPN (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365987	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calcutta Health Care Center	48444 Bell School Road Calcutta, OH 43920

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	#619) made the POA aware but not the physician because the POA did not want resident sent to the hospital; therefore, the nurse did not call the physician.Interview on 03/25/26 at 5:45 P.M. with LPN #619 verified she worked the night of 11/23/25 and stated Resident #98 had emesis that night but the POA did not want to send Resident #98 to the hospital. LPN #619 stated she observed the emesis to be a little dark brown but stated the emesis was enough Resident #98 needed her gown changed. LPN #619 verified she did not take additional vital signs that night and her intervention was to keep an eye on her. LPN #619 verified she did not call the physician after the brown emesis and revealed the resident had three to four emesis during the night to which she did not contact the physician. LPN #619 revealed she sent the PCP a text around 7:00 A.M. LPN #619 verified she passed medication to Resident #98 for the RISE medication pass time that could have been around 5:00 A.M. to 6:00 A.M. (unable to recall exact time). LPN #619 stated she provided Resident #98 fluids through the night but did not assess if her oral cavity was clear. LPN #619 verified vital sign monitoring should be done immediately with a change in condition and physician should be notified. LPN #619 stated she did not have concerns when speaking with the POA around 2:00 A.M. on 11/23/25 and suggested to wait until the physician was in the facility later that morning to see the resident. LPN #619 verified she did not call the POA again regarding the continued episodes of brown emesis that were significant enough to require gown changes.Interview on 03/26/26 at 11:19 A.M. with CNA #204 revealed she worked the morning shift on 11/23/25. CNA #204 stated she received report from the night CNA (CNA #704) stating Resident #98 was throwing up black all night. CNA #204 stated she observed Resident #98 around 8:00 A.M. moaning in bed and not responding and notified the nurse. CNA #204 stated she observed Resident #98 have a black emesis that was large enough Resident #98's bedding and gown needed changed.Interview on 03/26/26 at 1:58 P.M. with the DON revealed an investigation was not done related to Resident #98's change in condition and subsequent hospitalization. The DON verified LPN #619 did not document if or how many times the POA was called during the night. The DON verified the RISE medication was passed to Resident #98 during the morning of 11/23/25. The DON stated standard nursing practice was to call the physician if a resident had emesis and verified LPN #619 did not call the physician and additional vital sign monitoring or assessment were not completed or documented. The DON also verified no documentation existed regarding the times of emesis during the night or if the POA was additionally called.Interview on 03/26/26 at 3:13 P.M. with Medical Director #702 revealed it was the expectation of the facility to notify the physician any time of day or night if a resident had an acute change in condition. Medical Director #702 stated if the situation was critical the resident was to be sent to the ER and the physician and family called, and three or four brown/black emesis would be considered critical.Interview on 03/26/26 at 4:30 P.M. with Resident #98's PCP, PCP #701 revealed he received a text early in the morning on 11/23/25 and was not notified again until later in the morning around 7:00 A.M. by text that Resident #98 had brown like emesis. He stated an order for a CBC lab draw was made. PCP #701 stated it was his understanding the POA did not want the resident sent out to the hospital.Interview on 03/31/26 at 2:36 P.M. with CNA #704 revealed she worked the night shift on 11/22/25. CNA #704 reported she notified LPN #619 that Resident #98 had episodes of brown, mucus-like emesis and the resident needed gown changes. CNA #704 stated Resident #98 had approximately six episodes of emesis during the shift, including one large episode requiring a full bed change and CNA placed a towel by the resident's mouth. Review of the facility policy titled Acute Condition Changes Clinical Protocol, revised December 2015, revealed the nurse shall document and report vital signs, neurological status, pain, consciousness, onset duration and severity. Before contacting a physician about someone with an acute change of condition, the nursing staff would make detailed observations and collect pertinent information to report to the physician. The attending physician or practitioner providing back up coverage would respond in a timely manner (half hour or less) to notification of problems or changes in condition or status. The staff would notify the medical director for additional guidance or consultation if they did not receive a timely or appropriate response. The nurse and physician would discuss and evaluate the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365987	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calcutta Health Care Center	48444 Bell School Road Calcutta, OH 43920

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	situation. The physician should ask questions to clarify the situation, for example, vitals signs, physical findings, and symptoms description. The physician would discuss with staff and/or resident families the benefits and risks of diagnosing and managing the situation in the facility versus the hospital. The physician would identify and authorize proper treatment. The staff would monitor and document responses to treatment and the physician with adjust treatment accordingly until the problem has been resolved or stabilized. Review of facility undated policy titled Quality of Care Policy revealed it was the policy of the facility that each resident received the necessary care to attain or maintain the highest practicable wellbeing, in accordance with the resident's comprehensive care plan. Also, each resident must receive, and the facility must provide the necessary care and services to attain and maintain the highest practicable well-being in accordance with the comprehensive assessment and plan of care. This deficiency represents noncompliance investigated under Complaint Number 2769707.