STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366107	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rest Haven Nursing Home	2274 McDermott Pond Creek Road McDermott, OH 45652

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, interview, and policy review, the facility failed to notify the physician of repeated refusals of ordered weekly weights, as required by the physician order and the resident's plan of care. This affected one resident (#4) of one resident reviewed with weekly weight orders. The facility census was 21. Findings include:Record review for Resident #4 showed an admission date of 06/30/25, with diagnoses including chronic hepatitis C, morbid obesity, and generalized anxiety disorder. The care plan revised on 07/15/25 included interventions to obtain and monitor diagnostic work as ordered and report results to the physician. A subsequent revision on 07/16/25 instructed staff to notify the physician if the resident continuously declined weight measurements.Further review of the plan of care's revealed a revision on 07/16/25, Resident #4 was at risk for complications related to liver disease related to chronic hepatitis C with an intervention including but not limited to notifying medical doctor if continuously declines to be weighed.Review of a physician order dated 08/25/25 revealed an order for weekly weights every Monday on night shift, with directive to notify the physician if the resident refused to be weighed.Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #4 was cognitively intact. The resident was assessed to require total dependence on staff for toileting hygiene, shower/bathe, and transfers. This resident also did not exhibit any behaviors regarding rejection of care.Review of the medication administration record (MAR) for September 2025 through May 2026 revealed Resident #4 refused the weekly weight on 09/29/25, 10/13/25, 11/03/25, 11/10/25, 11/17/25, 12/08/25, 12/22/25, 01/05/26, 01/26/26, 02/09/26, 02/16/26, 02/23/26, 03/02/26, 03/09/26, 03/16/26, 03/23/26, 04/06/26, 04/13/26, 04/20/26, 04/27/26, 05/04/26, 05/11/26, 05/18/26 and 05/25/26. However, review of progress notes revealed no documentation that the physician had been notified of these refusals, despite repeated noncompliance with the weight order.During an interview on 05/27/26 at 1:50 P.M. Assistant Director of Nursing #140 confirmed Resident #4 had a weekly weight order since 08/25/25 and that staff failed to notify the physician of multiple documented refusals.Review of the facility's Medication Administration policy, revised 03/14/25, directed staff to report and document refusals.

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
	366107	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rest Haven Nursing Home	2274 McDermott Pond Creek Road McDermott, OH 45652

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure Pre-admission Screening and Resident Reviews (PASARR) were completed and updated to reflect a new qualifying diagnosis. This affected one resident (#6) of one resident reviewed for PASARR accuracy. The facility census was 21.Findings include:Record review for Resident #6 revealed the resident was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, anxiety, depression, paranoid schizophrenia added on 12/31/25, alcoholic polyneuropathy, hypertension, and peripheral vascular disease.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #6 was cognitively intact.Review of the most recent PASARR documentation provided by the facility for Resident #6 revealed it was completed prior to admission on [DATE], with no further documentation which reflected the addition of the new diagnosis.Interview with the Assistant Director of Nursing #140 on 05/27/26 at 2:29 P.M. verified a new PASARR had not been completed after discovery of a qualifying diagnosis for Resident #6.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and facility policy review, the facility failed to follow a physician's order to hold a dose of Coumadin (warfarin sodium) for Resident #20 after receiving a supratherapeutic International Normalized Ratio (INR) result. This failure resulted in the resident receiving an unnecessary dose of an anticoagulant despite a documented elevated INR level. This affected one resident (#20) of one resident receiving Coumadin. The facility census was 21. Findings include:Record review revealed Resident #20 was admitted on [DATE] with diagnoses including Parkinson's disease, longˆterm anticoagulant use, alcohol dependence in remission, major depressive disorder, and generalized weakness. The plan of care revised on 10/08/25 documented chronic embolism and thrombosis related to mitral valve insufficiency and repair, with an intervention to administer medications as ordered.Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #20 was cognitively intact. The resident was assessed to require supervision or touching assistance with bed mobility and transfers, partial/moderate assistance with toileting hygiene, and substantial/maximal assistance with shower/bathe.Laboratory review revealed the INR result obtained on 05/26/26 and received at 10:19 A.M. indicated a level of 3.7, above the moderate therapeutic range of 2.0-3.0. Despite this supratherapeutic value, review of the physician order dated 05/26/26 at 1:33 P.M. showed an order for warfarin sodium 7 milligrams (mg) daily for two days. Medication Administration Record (MAR) review confirmed the resident received the 7 mg dose on 05/26/26.A progress note entered on 05/27/26 at 10:06 A.M. by Assistant Director of Nursing (ADON) #140 documented that the physician clarified the Coumadin order, directing staff to hold Coumadin for two days, then resume at 6 mg daily, and recheck the INR the following week. At 10:30 A.M., ADON #140 documented the physician was notified that the nurse had misinterpreted the order and entered it incorrectly as an increased dose instead of holding it. As a result, the resident received 7 mg of Coumadin despite the elevated INR. A STAT INR was obtained, revealing a level of 3.8. The physician was updated and ordered Coumadin to be held with an INR recheck on 05/28/26.During an interview on 05/27/26 at 1:45 P.M., ADON #140 stated Resident #20 was the only resident in the facility on Coumadin, with weekly INR draws typically performed on Tuesdays and faxed to both the facility and physician. She reported that orders were usually obtained without issue until 05/26/26, when the resident received Coumadin 7 mg despite the supratherapeutic INR. She confirmed the nurse misunderstood the order, failed to document the elevated INR or communication with the physician in a progress note, and did not question the order despite the resident's INR level. The ADON stated she was developing a more reliable system to prevent miscommunication since laboratory results were faxed to both the physician and facility. She confirmed the resident's therapeutic INR range should be between 2-3.Review of the policy Medication Administration, revised 03/14/25, showed medications must be administered as ordered and per professional standards. Review of the policy Physician, Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist Lab Notification, revised 04/18/25, directed staff to immediately notify the practitioner of INR results, fax results, document communication and resident condition, and implement new orders.