STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366122	A. Building B. Wing	12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carecore at Mary Scott	3109 Campus Dr Dayton, OH 45406

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 - Minimal harm or potential for actual harm 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** 37100 Based on medical record review, review of a transportation communication log, resident and staff interviews, and facility policy review, the facility failed to provide proper and timely care/services to ensure a medical procedure was completed. This affected one (#9) of three residents reviewed for outside medical appointments. The census was 83. Findings Include: Resident #9 was admitted to the facility on [DATE]. His diagnoses were rhabdomylosis, congestive heart failure, alcohol dependence, alcoholic hepatitis, alcohol abuse, hepatic encephalopathy, dementia, depression, hypertension, and tobacco use. Review of Resident #9's minimum data set (MDS) assessment, dated 10/29/24, revealed he had a mild cognitive impairment. Review of Resident #9's Central Appointment Communication Sheet, dated 10/18/24, revealed he was to have an orthopedic appointment on 11/20/24. Handwritten on this form, it stated, rescheduled per [physician], awaiting cardiac clearance. There was no date as to when this order was given by the physician. Also, there were no progress notes in his medical record to support this appointment was scheduled, why it needed to be rescheduled, when it was to be rescheduled for, and when the appointment to get cardiac clearance was to be completed. Also, there was no documentation to support/confirm this was cardiac clearance or dental clearance. Review of Resident #9 Dental Clearance form, dated 10/31/24, revealed the original documented date for his hip surgery was scheduled for 11/25/24. However, Resident #9 did not receive dental clearance until 12/04/24. Review of Resident #9 progress notes, dated 10/15/24 to 11/25/24, revealed no documentation to support whether Resident #9 had his hip surgery completed as scheduled on 11/25/24. Additionally, there was no documentation to support the reason why, or documentation to support when the surgery was rescheduled for. Review of Resident #9 Central Appointment Communication Sheet, dated 11/27/24, revealed he was to have an appointment on 12/02/24 regarding laboratory and scan work to be completed. Review of his medical record found no evidence this appointment was completed. (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: 366122	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/27/2024
NAME OF PROVIDER OR SUPPLIER Carecore at Mary Scott		STREET ADDRESS, CITY, STATE, ZIP CODE 3109 Campus Dr Dayton, OH 45406	

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #9 medical records found no evidence that his total hip replacement surgery was scheduled for 12/09/24. Review of facility transportation communication log, dated December 2024, revealed Resident #9 was transportation was scheduled for a surgery to be completed on 12/09/24. There was no documentation to support whether this surgery was completed. Review of Resident #9 medical records, dated 10/15/24 to 12/27/24, and the facility transportation communication log, dated January 2025 to March 2025, revealed no documentation to support when his hip surgery had been rescheduled since he did not have the surgery completed on 12/09/24. Interview with Resident #9 on 12/27/24 at 1:00 P.M. confirmed he was to have his hip replacement surgery, but it got canceled because transportation didn't pick him up in time. He stated the facility transported him in the facility vehicle when they realized he had not been picked up, but by the time they go to the hospital, the surgeon stated he didn't have tome to complete the surgery because they were so late. He initially stated the date was 11/25/24, but then he confirmed he wasn't real clear with his dates at this time because he's had to cancel the surgery multiple times. He confirmed he did not have the hip replacement surgery as scheduled on 12/09/24. Interview with Director of Nursing (DON) and Administrator on 12/27/24 at 1:15 P.M. and 2:15 P.M. confirmed Resident #9 did not have his hip surgery on 11/25/24; it had to be rescheduled due to the surgeon needing dental clearance prior to having the surgery. They confirmed the request for a dental appointment to get clearance was made on 10/31/24, but the appointment was not completed and clearance given until 12/04/24. The DON also confirmed Resident #9 surgery did not happen on 12/09/24 due to transportation not showing up. She stated Resident #9 was to be picked up at 5:00 A.M., and then after two hours being in the lobby waiting, they decided to use their own vehicle to take him to the hospital. They confirmed Resident #9 did not have the surgery completed on that day due to being so late for his appointment time, so it was rescheduled again for January 2025. Review of facility Diagnostic Services Transportation policy, dated December 2008, revealed the facility will assist residents in arranging transportation to/from diagnostic appointments when necessary. Should it become necessary to transport a resident to a diagnostic service outside the facility, the social service designee or charge nurse shall notify the resident's representative and inform them of the appointment. The resident's representative will be responsible for transporting the resident to his or her lab appointment. Should it be necessary for the facility to provide transportation, the social service designee will be responsible for arranging the transportation through the business office. A member of the nursing staff or social services, will accompany the resident to the diagnostic center when the resident's family is not available and resident is required to have 1:1 assistance. Requests for transportation should be made as far in advance as possible. The use of volunteers to transport residents to appointments must be approved by the administrator. This deficiency represents non-compliance investigated under Complaint Number OH00160678.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366122	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on medical record review, review of a transportation communication log and staff interview, the facility failed to maintain complete resident medical records regarding outside medical appointments. This affected three (#9, #20, and #35) of three residents reviewed for outside medical appointments. The census was 83. Findings Include: 1. Resident #9 was admitted to the facility on [DATE]. His diagnoses were rhabdomylosis, congestive heart failure, alcohol dependence, alcoholic hepatitis, alcohol abuse, hepatic encephalopathy, dementia, depression, hypertension, and tobacco use. Review of Resident #9's minimum data set (MDS) assessment, dated 10/29/24, revealed he had a mild cognitive impairment. Review of Resident #9's Central Appointment Communication Sheet, dated 10/18/24, revealed he was to have an orthopedic appointment on 11/20/24. Handwritten on this form, it stated, rescheduled per [physician], awaiting cardiac clearance. There was no date as to when this order was given by the physician. Also, there were no progress notes in his medical record to support this appointment was scheduled, why it needed to be rescheduled, when it was to be rescheduled for, and when the appointment to get cardiac clearance was to be completed. Also, there was no documentation to support/confirm this was cardiac clearance or dental clearance. Review of Resident #9 Dental Clearance form, dated 10/31/24, revealed the original documented date for his hip surgery was scheduled for 11/25/24. However, Resident #9 did not receive dental clearance until 12/04/24. Review of Resident #9 progress notes, dated 10/15/24 to 11/25/24, revealed no documentation to support whether Resident #9 had his hip surgery completed as scheduled on 11/25/24. Additionally, there was no documentation to support the reason why, or documentation to support when the surgery was rescheduled for. Review of Resident #9 Central Appointment Communication Sheet, dated 11/27/24, revealed he was to have an appointment on 12/02/24 regarding laboratory and scan work to be completed. Review of his medical record found no evidence this appointment was completed. Review of Resident #9 medical records found no evidence that his total hip replacement surgery was scheduled for 12/09/24. Review of facility transportation communication log, dated December 2024, revealed Resident #9 was transportation was scheduled for a surgery to be completed on 12/09/24. There was no documentation to support whether this surgery was completed. Review of Resident #9 medical records, dated 10/15/24 to 12/27/24, and the facility transportation communication log, dated January 2025 to March 2025, revealed no documentation to support when his hip surgery had been rescheduled since he did not have the surgery completed on 12/09/24. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Carecore at Mary Scott		STREET ADDRESS, CITY, STATE, ZIP CODE: 3109 Campus Dr Dayton, OH 45406	

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #20 was admitted to the facility on [DATE]. His diagnoses were paraplegia, chronic multifocal osteomyelitis, asthma, polyneuropathy, pressure ulcer of sacral region stage IV, and sepsis. Review of Resident #20's MDS assessment, dated 11/04/24, revealed he was cognitively intact. Review of facility transportation communication log, dated October 2024, revealed Resident #20 was to have a radiology appointment at the hospital on 10/09/24. Review of Resident #20 medical records found no documentation whether this appointment was completed. 3. Resident #35 was admitted to the facility on [DATE]. His diagnoses were interstitial pulmonary disease, respiratory disorders, asthma, chronic respiratory failure, immunodeficiency with predominantly antibody defects, other pulmonary aspergillosis, acute and chronic respiratory failure, morbid obesity, anxiety disorder, opioid dependence, attention deficit hyperactivity disorder, hypoxemia, hypertension, sedative hypnotic use, and depression. Review of Resident #35's MDS assessment, dated 10/01/24, revealed he was cognitively intact. Review of facility transportation communication log, dated December 2024, revealed Resident #35 was to have a dental appointment on 12/19/24. Review of Resident #35 medical records found no documentation whether this appointment was completed. Interview with Director of Nursing (DON) and Administrator on 12/27/24 at 1:15 P.M. and 2:15 P.M. confirmed they got no paperwork from Resident #9 surgeon when there is a change in schedule or consent needed; they receive a phone call and they are to follow the verbal orders. They confirmed there was no documentation to support any of the communication from the surgeon, why the the surgeries were canceled, when the surgeries would be rescheduled for, and documentation about transportation being late/his surgery not being completed on 12/09/24. They also confirmed his surgery was rescheduled for January 2025, but there was no documentation to support what day the surgery was, or if transportation had been acquired/arranged for this appointment. Also, they confirmed they do not have consent to get Resident #35 dental appointment after-visit notes, so they obtained consent on 12/27/24 and sent it to the dentist office to get the documentation. They confirmed they do not know what was on the after visit documentation to know if there was follow up care needed. Lastly, they confirmed they do not have documentation about Resident #20 appointment for radiology and why it did not occur. This deficiency represents non-compliance investigated under Complaint Number OH00160678.