

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 12/13/2025
NAME OF PROVIDER OR SUPPLIER Carecore at Mary Scott		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (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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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview, record review, and facility policy review, the facility failed to allow a resident to determine their own treatment options. This affected one (#43) of two residents reviewed for exercising treatment options. The facility census was 71. Findings include: An admission Record revealed the facility admitted Resident #43 on 07/12/25. According to the admission Record, Resident #43 had a medical history that included diagnoses of type II diabetes mellitus, essential hypertension, old myocardial infarction (heart attack), unspecified diastolic heart failure, atherosclerotic heart disease, schizophrenia, psychosis, depression, adjustment disorder with mixed anxiety and depressed mood, and attention-deficit hyperactivity disorder-combined type. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/20/25, revealed Resident #43 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #43 did not exhibit hallucinations, delusions, or rejection of care during the assessment timeframe. Resident #43's Care Plan Report revealed no documentation related to repeatedly requesting to be transferred to the hospital. Resident #43's Progress Notes revealed a note, dated 08/23/25 at 12:14 A.M., that indicated that Resident #43's roommate got the nurse and told her that Resident #43 was not doing well. The note indicated that on assessment, the nurse found Resident #43 to be pale, with their skin clammy and cool to the touch. The note indicated that the resident was twitching uncontrollably, had urinated on themselves and was unstable. The note revealed that Resident #43 requested to go to the hospital. Per the note, the nurse called the primary care provider (PCP), who ordered laboratory tests, including a drug screen, and to monitor the resident. The note indicated that Resident #43 informed the nurse that they had nothing to eat. The note indicated that the nurse provided the resident with a sandwich. The note indicated that the nurse monitored the resident for the rest of the shift and had no further concerns. Resident #43's Progress Notes revealed a note, dated 09/09/25 at 12:18 P.M., that revealed that earlier in the shift, Resident #43 reported difficulty breathing. The note indicated that the resident's vital signs were checked. The note revealed that the resident appeared to be sweating and shaking off and on. The progress note revealed that Resident #43 requested to go to the emergency room (ER). The note indicated that when the nurse asked the resident to explain the problem, the resident requested that the nurse not tell the PCP their oxygen saturation. The note indicated that after the nurse informed Resident #43 that the PCP would be told all their vital signs, the resident seemed to calm down. Resident #43's Progress Notes revealed a note, dated 10/19/25 at 2:13 A.M., that revealed that during the night medication pass, the resident complained of diarrhea and was not feeling well. The note indicated that earlier, Resident #43 had complained to the day shift nurse. The note indicated that the nurse gave the resident medication for diarrhea. The note indicated that at 2:00 A.M., Resident #43 approached the nurse and Resident #43 was reminded the nurse had given medication to the resident earlier. Per the note, Resident #43 told the nurse they wanted to go to the hospital due to nausea and continued not to feel well from earlier. The note indicated that the PCP was notified, and a voice message was left. The note indicated that medication was given for nausea and indicated that monitoring would continue. Resident #43's Progress Notes revealed a note, dated 10/19/25 at 5:39 P.M., that indicated that Resident #43 had complaints of chest pain and wanted to be sent to the hospital. The note indicated that the PCP was contacted and instructed the nurse to give the resident an antacid and a muscle relaxer. During an interview on 09/29/25 at 11:14 A.M., Resident #43 stated that Licensed Practical Nurse (LPN) #2 knew there had been a time they wanted to go to the hospital, but the PCP would not let them be sent. The resident stated that they did not sleep for two nights and sweated during the day. Resident #43 stated that the facility staff finally drew blood for laboratory testing, but they felt better by that time. During a follow up interview with Resident #43 on 12/08/25 at 9:38 A.M., Resident #43 stated that LPN #2 knew they wanted to go to the hospital, but her hands were tied because the PCP would not agree to send the resident. The resident stated that around 10/19/25, they had felt bad the entire weekend. Resident #43 stated that when the nurse called the PCP, the PCP stated that the resident had no history of cardiac issues. Resident #43 stated that the chest pain radiated down their left arm. Per the resident, the problem turned out to be anxiety, but they still did not understand why the PCP would not allow the resident to be sent to the hospital for chest pain. LPN #2 was interviewed on 12/09/25 at 10:43 A.M. LPN #2 stated she remembered when Resident #43 requested to go to the hospital and requested she not tell the PCP what their oxygen level was and had told her that their oxygen level dropped when they laid down. The Social Services Director (SSD) was interviewed on 12/11/25 at 11:41 A.M. The</p>		

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<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>(continued on next page)</p>

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<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident was provided with reasonable access to a telephone in a private setting. This affected one (#23) of two residents reviewed for privacy. The facility census was 71. Findings include: An admission Record indicated the facility admitted Resident #23 on 11/21/17. According to the admission Record, the resident had a medical history that included diagnoses of paranoid schizophrenia, unspecified psychosis, anxiety disorder, and personality disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/14/25, revealed Resident #23 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident was independent with activities of daily living (ADLs). The MDS also indicated the resident had delusions, verbal behavioral symptoms directed toward others, and behavioral symptoms not directed towards others. Resident #23's Care Plan Report, initiated 02/14/25, indicated the resident had a potential for altered behavioral patterns, inappropriate verbal behaviors, intolerance of peers, and yelling at staff and residents. Interventions directed staff to be careful not to invade Resident #23's personal space and to be respectful of the resident's privacy. An observation on 12/10/25 at 3:26 P.M. revealed Resident #23 exited the second floor elevator and proceeded to the telephone station located directly across from the elevators. The observation revealed the telephone station was situated in an open area without doors or walls which allowed residents, staff, and visitors to unintentionally overhear telephone conversations. Resident #23 was observed sitting on their rollator walker (a mobility device with a seat) making a telephone call. An observation on 12/10/25 at 3:30 P.M. revealed another resident and staff exited the elevator and walked passed Resident #23, who was actively engaged in a telephone conversation. During an interview on 12/08/25 at 2:52 P.M., Certified Nursing Assistant (CNA) #14 stated the facility had phones that were not portable for residents to use and privacy was a concern as the designated phone station was an open area with no walls. During an interview on 12/10/25 at 3:43 P.M., Resident #23 stated, There is no privacy. Resident #23 stated they would rather use the telephone on the second floor than the phone on the first floor, where their room was located, due to less people walking by. During a concurrent observation and interview on 12/11/25 at 9:06 A.M., CNA #13 stated the facility had a phone in each station. The observation revealed a phone by the back nursing station close to the rehabilitation room, and there were no walls surrounding the nursing station. An observation of the middle nursing station, close to the elevator, revealed there was no phone that was easily accessible to the residents. The observation revealed the phone was located inside the oxygen storage room/nurse charting (documentation) room with a sign indicating the room was for staff only. CNA #13 stated the phone used to be located by the middle nursing station. During an interview on 12/11/25 at 10:49 P.M., Licensed Practical Nurse (LPN) #16 stated phones were down the 300 hallway and by the nursing station on the 400 hallway. LPN #16 stated the phones were located in the open. LPN #16 stated they used to have a phone by the snack machine but did not think the phone was there anymore. During an interview on 12/12/25 at 2:51 P.M., the Infection Preventionist (IP) stated residents had access to phones by the stations. The IP stated he offered residents use of his office for private phone calls as the nursing stations were open and the facility did not have a designated room for resident calls. During an interview on 12/13/25 at 9:48 A.M., the Interim Director of Nursing (IDON) stated residents should have access to a private area to use the telephone. The IDON stated the facility did not want residents to feel that staff or others might overhear their telephone conversations, particularly when discussing personal information. During an interview on 12/13/25 at 10:50 A.M., the Administrator stated the residents should have privacy when using the facility telephones. A facility policy titled, Resident Rights, revised February 2021, indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to access to a telephone, mail, and email; and communicate in person and by mail, email and telephone with privacy. A facility policy titled, Telephones, Resident Use of, revised May 2017, indicated, Designated telephones are available to residents to make and receive private telephone calls. Telephones will be in areas that offer privacy and accommodate the hearing impaired and wheelchair-bound residents. This deficiency represents noncompliance investigated under Complaint Number 2612053.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, record review, and interview, the facility failed to report allegations of abuse to the State Survey Agency (SSA). This affected three (#69, #43, and #78) of three residents reviewed for abuse. The facility census was 71. Findings include: 1. An admission Record revealed the facility admitted Resident #69 on 07/12/25. According to the admission Record, the resident had a medical history that included a diagnosis of unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/15/25, revealed Resident #69 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident did not exhibit physical behavioral symptoms directed toward others or verbal behavioral symptoms directed toward others during the assessment timeframe.</p> <p>Resident #69's Care Plan Report included a focus area initiated 07/30/25, that indicated the resident had impaired cognitive function/impaired thought process related to dementia. Undated interventions directed staff to communicate with the resident/family/caregivers regarding the resident's capabilities and needs.</p> <p>During a telephone interview on 12/10/25 at 10:34 A.M., Certified Nursing Assistant (CNA) #9 stated that on 12/06/25, Resident #69 told her that Registered Nurse (RN) #10 shoved a bedside table into the resident's knee and that the nurse was rough and disrespectful. She stated that she called the Interim Director of Nursing (IDON) to report the allegation. She stated that the IDON told her she did not believe the CNA. She stated that the resident continued to talk about the incident for the rest of her shift.</p> <p>During an interview on 12/10/25 at 11:14 A.M., Resident #69 stated that a staff member took the resident's table and slammed it against the resident's legs. The resident stated that there was water in a cup and it spilled. Resident #69 stated that the staff did not care or excuse themselves. The resident stated that they (Resident #69) told other staff that the staff member slammed the table into the resident's legs and spilled water, but the resident could not remember who they told.</p> <p>During an interview on 12/10/25 at 1:02 P.M., CNA #11 stated that on 12/06/25, Resident #69 was walking the hall stating that a table was hit against their leg and hurt their leg. She stated that she did not ask the resident who bumped the table into the resident's leg.</p> <p>During a telephone interview on 12/10/25 at 2:31 P.M., RN #10 stated that when she was in Resident #69's room, the resident accused her of spilling water on the resident. She stated that when the resident came out of the resident's room, the resident accused her of shoving a table into the resident's leg. She stated she called the IDON immediately after the resident accused her of shoving the table into the resident's leg to report the allegation.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/10/25 at 3:42 P.M., the IDON stated that RN #10 reported to her that Resident #69 had alleged RN #10 spilled water on the resident. She stated that CNA #9 had reported to her that the CNA heard Resident #69 state that RN #10 was rude. The IDON stated that she denied the Administrator's phone number to CNA #9 because she did not feel it was appropriate to hand it out. She stated that the Administrator was the Abuse Coordinator.</p> <p>During a follow-up interview on 12/10/25 at 4:33 P.M., the IDON stated that being rude was not an allegation of abuse because it did not sound like RN #10 was being abusive. She stated that the allegation that water was spilled was an allegation of abuse if it was purposeful. She stated that abuse needed to have occurred for it to be reportable to the SSA. She stated that when she investigated the allegations, she did not find abuse.</p> <p>During a follow-up interview on 12/11/25 at 8:42 A.M., CNA #9 stated that she requested the Administrator's phone number via a text message on 12/06/25 at 9:14 P.M. to the IDON, and the IDON refused.</p> <p>The resident's record revealed no evidence that the allegations were reported to the SSA.</p> <p>During an interview on 12/11/25 at 3:30 P.M., the Administrator stated that the IDON called her late on 12/06/25 or early 12/07/25 to report that CNA #9 did not want to obtain vital signs, and she and RN #10 had a history of not getting along elsewhere. The Administrator stated that she was not aware of water being spilled or a table being shoved against Resident #69's legs. She stated that it depended on the intent whether the water being spilled on the resident was an allegation of abuse. The Administrator stated that CNA #9, CNA #11, and RN #10, who heard Resident #69 allege that a table was shoved into the resident's legs, should have reported to the IDON or to herself. She stated that the IDON should not have denied CNA #9 her phone number. She stated that she was not aware that CNA #9 had called the IDON about the incident. She stated that she expected staff to report allegations of abuse immediately to the DON who would then report it to her, or they could report the allegation to her themselves. She stated that the facility had two hours to report an allegation of physical abuse to the SSA. She stated that the allegations should have been reported to the SSA when they were reported to the IDON.</p> <p>2. An admission Record revealed the facility admitted Resident #43 on 07/12/25. According to the admission Record, Resident #43 had a medical history that included diagnoses of type II diabetes mellitus, essential hypertension, old myocardial infarction (heart attack), unspecified diastolic heart failure, atherosclerotic heart disease, schizophrenia, psychosis, depression, adjustment disorder with mixed anxiety and depressed mood, and attention-deficit hyperactivity disorder-combined type.</p> <p>A quarterly MDS, with an ARD of 10/20/25, revealed Resident #43 had a BIMS score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #48 did not exhibit hallucinations, delusions, or rejection of care during the assessment timeframe.</p> <p>Resident #43's Care Plan Report revealed no documentation that indicated Resident #43 fabricated stories about staff.</p> <p>During an interview on 09/29/25 at 11:14 AM, Resident #43 stated that CNA #18 told them (Resident #43) to shut up. The resident stated that the CNA told them to shut up when they removed sugar from a coffee cart. The resident stated that the CNA refused to respond when spoken to and was very rude.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The resident's allegation was reported to the Administrator on 09/29/25 at 11:45 A.M.</p> <p>Upon returning to the facility on [DATE], a surveyor request was made for all the allegations of abuse that were reported to the SSA. There was no report for the allegation that Resident #43 made against CNA #18.</p> <p>The Social Services Director (SSD) was interviewed on 12/11/25 at 11:40 A.M. The SSD stated that the allegation of verbal abuse involving Resident #43 was not discussed with her in September 2025, after making the Administrator aware that the resident reported that CNA #18 told the resident to shut up. The SSD stated that any staff member telling a resident to shut up would be a form of abuse.</p> <p>The IDON and Regional Director of Clinical Services (RDCS) #21 were interviewed on 12/12/25 at 2:28 P.M. The IDON stated that if she became aware of an allegation of abuse, she immediately reported it to the Administrator, and the alleged perpetrator was suspended pending outcome of the investigation. The IDON stated that CNA #18 was still employed but had not been in the building for months due to a health issue. The IDON stated that if a staff member told a resident to shut up, it was verbal abuse, and the abuse should be reported immediately, then the facility had two hours to report the allegation of abuse to the SSA. The IDON stated that the incident between Resident #43 and CNA #18 had not been discussed at a morning meeting. RDCS #21 stated that she was unaware of the allegation of verbal abuse.</p> <p>An interview was held with the Administrator on 12/12/25 at 4:43 P.M. The Administrator stated that she had not reported Resident #43's allegation of abuse to the SSA, which had been reported to her on 09/09/25. She stated that she may have gotten distracted and forgot to write the allegation down and had forgotten the incident.</p> <p>3. An admission Record revealed the facility had admitted Resident #78 on 07/20/23. According to the admission Record, the resident had a medical history that included diagnoses of severe recurrent major depression without psychotic features, anxiety disorder, attention-deficit hyperactivity disorder, post-traumatic stress disorder, and cerebral palsy.</p> <p>An annual MDS, with an ARD of 06/30/25, revealed Resident #78 had a BIMS score of 15, which indicated the resident had intact cognition. The MDS indicated that Resident #78 scored seven on the Resident Mood interview, which indicated the resident had mild depressive symptoms. The MDS revealed Resident #78 exhibited no behavioral symptoms during the assessment lookback period.</p> <p>Resident #78's Care Plan Report included a focus area initiated on 07/25/23, that revealed the resident wanted to return to the community after a short-term stay for rehabilitation. The Goal was to achieve discharge as planned, with a target date of 09/28/25. Undated interventions directed staff to encourage the resident to follow up with their primary care physician after discharge, encourage the resident and the family to be realistic with expectations, encourage the resident to be as independent as possible, review goals and confirm discharge plans with the resident and family, make referrals as recommended by the interdisciplinary team, and to provide one-to-one visits as needed to assess progress towards discharge plans. The Care Plan Report included a focus area initiated 07/26/23, that indicated Resident #78 had a history of polysubstance abuse. Undated interventions directed staff to gently redirect the resident when/if behaviors occurred and to notify the physician of any suspected substance abuse.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An Emergency Notice of Discharge, dated 09/09/25, indicated that Resident #78 was being discharged because the health of other individuals in the facility was endangered. The specific allegations were listed as, Death threat made to a resident in the facility, and Firearms, knife, vial of various pills, fake and real looking police badge were found in the resident's room. The discharge notice indicated that the resident was being discharged to either their home or a homeless shelter.</p> <p>Resident #78's record revealed no evidence of the resident threatening another resident being reported to the SSA.</p> <p>The IDON was interviewed on 12/10/25 at 3:11 P.M. The IDON stated that staff should report an allegation of abuse immediately to their supervisor, herself, or the Administrator. The IDON stated that the Abuse Coordinator for the facility was the Administrator. The IDON stated that when there was an allegation of abuse, the facility had two hours to report the allegation to the SSA.</p> <p>The SSD was interviewed on 12/11/25 at 11:45 A.M. The SSD stated that Resident #78 was discharged because they had brought air soft rifles and handguns that were lifelike into the facility. The SSD stated that the items were found the day before the resident was discharged . The SSD stated that Resident #78 showed the articles to another resident and threatened to harm that resident, and that resident felt fearful.</p> <p>The Administrator was interviewed on 12/12/25 at 4:52 P.M. The Administrator stated that since Resident #78's discharge notice indicated that the resident was being discharged for threatening another resident, it should have been reported to the SSA.</p> <p>A facility policy titled, Abuse, Neglect and Exploitation, last reviewed 01/22/25, indicated, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. The policy revealed, VII. Reporting Response included, A. The facility will have written procedures that include, 1. Reporting of all alleged violations to the Administrator, state agency and to all other required agencies (e.g. [exempli gratia; for example], law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.</p> <p>This deficiency represents noncompliance investigated under Master Complaint Number 2688424.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observation, interview, and facility document and policy review, the facility failed to ensure food was prepared and served in accordance with professional standards for food service safety. Specifically, the facility failed to ensure staff wore beard restraints during food preparation, and the facility failed to ensure chemical test strips used to check the concentrations of sanitizing solutions were not expired. This affected all residents who ate food prepared in the kitchen. Findings include: 1. An observation on 12/10/25 at 9:45 A.M. revealed Dietary [NAME] (DC) #5 was not wearing a beard restraint to cover his beard and mustache while preparing pork chops and cornbread. An observation on 12/10/25 at 11:47 A.M. revealed DC #6's hair restraint was not covering his beard while he was preparing mechanically altered pork chops. An observation on 12/10/25 at 11:54 A.M. revealed DC #6's hair restraint was not covering his beard while he was preparing pureed pork chops. An observation on 12/10/25 at 12:04 P.M. revealed DC #6's hair restraint was not covering his beard while he was preparing mechanically altered coleslaw. During an interview on 12/10/25 at 2:47 P.M., DC #5 stated that he should have worn the beard restraint to cover his beard and mustache as soon as he entered the kitchen. DC #5 stated he should have worn the beard restraint so that no hair fell on the food and for infection control reasons. During an interview on 12/10/25 at 2:58 P.M., DC #6 stated he should have covered both his beard and mustache while in the kitchen, so that no loose hair went to the food. During an interview on 12/11/25 at 3:11 PM, the Dietary Manager (DM) stated staff should use hair restraints to cover their beards and mustaches until the beard restraints could be ordered so that no hair follicles fell in the food to contaminate the food. During an interview on 12/11/25 at 3:23 P.M., the Dietetic Technician Registered (DTR) stated hair restraints to cover the beards and mustaches should have been used so that hair did not go in the food. During an interview on 12/13/25 at 10:59 A.M., the Administrator stated hair restraints should be worn before entering the kitchen and should cover the head, beard, and mustache to prevent contamination of food. A facility policy titled, Food Preparation and Service, revised April 2019, indicated, Policy Statement - Food and nutrition services employees prepare and serve food in a manner that complies with safe food handling practices. The section Food Preparation Area revealed 5. Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness. The section Food Service/Distribution revealed 7. Food and nutrition services staff wear hair restraints (hair net, hat, beard restraint, etc.[et cetera, and other similar things]) so that hair does not contact food. 2. During a concurrent observation and interview on 12/10/25 at 10:12 A.M., the Dietary Manager (DM) indicated ammonium chloride was the sanitizing solution used for pots and pans and when sanitizing kitchen surfaces. An observation of the DM using QT-40 strips to test two buckets of sanitizing solution revealed the DM stated the strips' expiration date was 10/15/16, and she would order a new test strips because they were not effective. During an interview on 12/10/25 at 10:18 A.M., the DM revealed a chlorine based sanitizing solution was used during the final rinse of the facility's low temperature dishwashing machine. The DM stated the chlorine test strips' expiration date was June 2024, and she would order new ones because the strips were not effective. During an interview, on 12/11/25 at 3:23 P.M., the DTR stated the dietary staff should have checked the expiration dates of the testing strips used in checking the concentration of sanitizing solutions. The DTR stated the testing strips should not be expired to make sure the chemicals sanitized well. During an interview on 12/13/25 at 10:50 A.M., the Administrator stated the testing strips should not be expired and should be within date to show a true outcome of what was tested and to avoid false negative testing. A facility policy titled, Sanitization, revised November 2022, indicated, Policy Statement: The food service area is maintained in a clean and sanitary manner. The policy also indicated, 3. All equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions. The section Low-Temperature Dishwasher (Chemical Sanitization) indicated, (3) The chemical solution is maintained at the correct concentration, based on periodic testing, at least once per shift, and for the effective contact time according to manufacturer's guidelines. The policy also indicated 6. Manual washing and sanitizing is a three-step process for washing, rinsing and sanitizing, and Chemical sanitizing solutions (e.g. [exempli gratia, for example], chlorine, iodine, quaternary ammonium compound) are used according to manufacturer's instructions. A facility document titled [Brand Name] QT-40 [Quaternary 40, chemical test strips used to measure the concentration of quaternary ammonium in sanitizing solutions] revealed a copy of the bottle label of the facility's test strips. The label revealed the expiration date of the facility's QT-40 test strips was 10/15/16 and the label did not indicate the reference range for the correct concentration of</p>		