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	03/25/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of a facility document, review of email correspondence, and policy review, the facility failed to ensure timely assistance with a resident/family initiated request for discharge to another facility. This affected one (Resident #27) out of three residents reviewed for discharge. The facility census was 64.Findings Included:Review of the medical record revealed Resident #27 was admitted to the facility on [DATE]. Diagnoses included type two diabetes, dementia, nutritional deficiency, acute kidney failure, transient ischemic attack, and atherosclerotic heart disease.Review of the quarterly minimum data set (MDS) dated [DATE] revealed Resident #27 had a Brief Interview for Mental Status (BIMS) score of eight documented cognitive impairment. Resident #27 was set up or clean-up for oral care, and personal hygiene. Resident #27 was independent for personal hygiene, toileting, bathing, dressing upper and lower body, and placing shoes on and off feet. Review of a progress note dated 01/21/26 the Licensed Practical Nurse (LPN) #300 documented Resident #27 stated she was supposed to move to another facility today, Resident #27 was informed she had no transfer or discharge orders to leave the facility. Resident #27 became agitated and was redirected multiple times.Review of a progress note dated 01/23/26 the Social Service Worker (SSW) #240 spoke with Resident #27's daughter and guardian about recent behaviors. Resident #27's daughter stated she was requesting a transfer to another facility with a memory care unit. The referral has been sent.Review of an admission progress note dated 02/05/26 the Admissions Director (AD) #162 spoke with Resident #27's daughter, who was also power of attorney, who wanted referrals sent to other facilities with memory care units. AD #162 reached out to their Senior Social Worker #250 to assist with the request.Review of a facility document titled Durable Power of Attorney for Financial Matter date April 2025 revealed it was signed by Resident #27, her family, and a witness.Review of an email correspondence dated 02/05/26 from the AD #162 to the Senior Social Worker #250 that Resident #27's daughter, also the power of attorney, would like the resident moved to another facility with a memory care unit. The AD #162 documented Resident #27's daughter would like the referrals sent to the following facilities and listed five facilities by name in the email. A return email by the Senior Social Worker #250 documented she would take care of these by the end of the business today (02/05/26). Review of an email correspondence dated 02/12/26 from the AD #162 to the Senior Social Worker #250 requesting an update. The Senior Social Worker #250 replied to the email she would physically be in the building on Tuesday. The email correspondence further documented she had state in three of her facilities and it was a little crazy.Interview on 03/25/26 at 9:45 A.M., SSW #240 said he sent the referral on 01/23/26 and he was let go from his work position on the same day. Resident #27 told the facility she wanted to leave. The SSW #240 said he spoke with the daughter who said she wanted her mother, Resident #27, to go to another facility. Resident #27 was having behaviors and really did not want to stay at this facility. Interview on 03/25/26 at 10:10 A.M., the Senior Social Worker #250 said she told AD #162 to send the referrals for Resident #27. Interview on 03/25/26 at 11:00 A.M., the AD #162 said she was not told to send the referrals out. The AD #162 further said the Senior Social Worker #250 told her she was (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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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sending the referrals out for Resident #27 in an email. The AD #162 verified there was only one referral sent out on 01/23/26. Review of the facility policy titled Discharge Planning Policy and Procedures, dated 07/28/25 revealed the facility was committed to ensuring that all residents discharges are conducted in a safe, person-centered, and compliant manner in accordance with Center of Medicaid and Medicare regulations. Discharges will be planned collaboratively with the residents, their representatives, and the interdisciplinary team, with a focus on continuity of care, residents' rights, and regulatory compliance.This deficiency represents non-compliance investigated under Complaint Number 2805346.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and policy review, the facility failed to ensure weekly skin assessments and treatments were completed as ordered. This affected one (Resident #23) out of three residents reviewed for wounds. The facility census was 64.Findings Included:Review of the medical record for Resident #23 revealed an admission date of 08/27/22. Diagnoses included morbid obesity, anxiety disorder, nonpsychotic mental disorder, schizoaffective disorder, chronic pain syndrome, osteoarthritis, and major depression. Review of the minimum data set (MDS) assessment dated [DATE] revealed Resident #23 had Brief Interview of Mental Status (BIMS) score of 10 revealing she had moderate cognitive impairment. Resident #23 was bed bound and required staff assistance for activities of daily living (ADL). Review of the weekly skin assessment dated from 12/18/25 where the heel wound was identified through 03/23/26 revealed Resident #23 had skin assessments on 02/03/26 and 03/17/26. Review of the treatment administration record (TAR) dated from 12/18/25 through 03/24/26 revealed the left heel wound was documented as completed. Specifically, on the dates 03/21/26 Licensed Practical Nurse (LPN) #204 signed the treatment was completed. On 03/22/26, LPN #202 signed the treatment was completed. On 03/23/26, LPN #155 signed the treatment was completed.Review of a physician order dated 03/06/26 revealed Resident #23 had a wound care order to cleanse the left heel with wound cleanser or normal saline, pat dry, apply collagen to the wound bed, and cover with a border foam dressing every night and as needed.Review of the plan of care dated 03/24/26 revealed Resident #23 was at risk for skin breakdown related to incontinence, decreased mobility, impaired cognition secondary to dementia and obesity. Resident #23 was resistive to care and turning and repositioning. A treatment was in place for the left heel. Interventions included complete skin treatments, monitor effectiveness, change treatments as indicated per physician orders, encourage residents to turn and reposition every two hours and as needed.Observation and interview on 03/24/26 at 11:24 A.M., of Resident #23's left heel dressing with LPN #206 verified the dressing on Resident #23's left heel was dated 03/22/26 with the initials of LPN #204. LPN #206 verified the dressing on Resident #23's left heel was two days old. The Director of Nursing (DON) was in the room at the time of the observation.Interview on 03/24/26 at 12:15 P.M., the DON also verified Resident #23's left heel dressing had the date of 03/22/26. The DON verified LPN #204 worked night shift on 03/21/26 and dated the dressing of the left heel 03/22/26 and signed the TAR on 03/21/26. Interview on 03/24/26 at 12:22 P.M., LPN #202 stated he did not know Resident #23 had treatment for her left heel. LPN #202 stated he was not falsifying documentation when signing the treatment off. LPN #202 verified he had not completed the left heel treatment on 03/22/26. During a follow-up interview on 03/24/26 at 2:02 P.M., the DON stated she expected nursing staff to complete skin assessments weekly and document the findings on the facility skin review that it was done; unless a resident refused or was out of the facility. The DON verified Resident #23 had only two skin assessments completed on 02/03/26 and 03/17/26. The DON said the wound had improved and it was smaller in size.Review of the facility policy titled Wound Care dated 2001 revealed the purpose of this procedure was to provide guidelines for the care of wounds to promote healing. Notify the supervisor if the resident refuses the wound care. Report other information in accordance with facility policy and professional standards of practice.Review of the facility policy titled Pressure Injury Risk Assessment dated ?2001' revealed that the purpose of this procedure was to provide guidelines for the structured assessment and identification of residents at risk of developing new pressure injuries or worsening of existing pressure injuries. The risk assessment should be conducted as soon as possible after admission, but no later than eight hours after admission was completed. Repeat the risk assessment weekly for the first four weeks, if there was a significant change in condition, or as often as was required based on the resident's condition. Conduct a comprehensive skin assessment with every risk assessment. This deficiency represents non-compliance investigated under Complaint Number 2784368.