

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on interview, observation, record review, and facility policy review, the facility failed to date opened vials of insulin and failed to remove expired insulin from two of four medication carts observed. The facility census was 71. Findings include: An observation on 12/12/25 at 9:45 A.M. of the medication cart for the 100 Hall revealed a vial of Lantus (a type of insulin) with an open date of 11/13/25. During a concurrent interview, Licensed Practical Nurse (LPN) #7 stated Lantus was good for 28 days after the open date, which meant the vial of Lantus was expired and should have been removed from the medication cart. LPN #7 stated that the medication carts were checked weekly during the medication cart audits, and the nurse giving the medication was expected to check the labels of medications for expiration dates prior to giving the medication. LPN #7 stated she would discard the expired insulin. An observation on 12/12/25 at 9:55 A.M. of the medication cart for the 200 Hall revealed one vial of insulin that had an open date of 10/31/25. Three vials of insulin had been opened, insulin used, and the vials were left undated as to when they were opened. During an interview on 12/12/25 at 9:55 P.M., LPN #8 stated the insulins were good for a month after opening. LPN #8 stated she had no information on the medication cart that identified when each type of insulin expired, and she just had to remember. LPN #8 stated if a resident was given an insulin that had expired, the insulin may not be as effective in controlling the resident's blood sugar. LPN #8 stated it was the responsibility of the nurse that opened the vial of insulin or opened the insulin pens to place a date on the containers when opened. During an interview on 12/12/25 at 11:32 A.M., the Infection Preventionist (IP) stated the unit managers were responsible for checking the carts weekly to make sure all medications were labeled, dated, and remove all expired, discontinued, and opened but undated medications. The IP stated that removing those medications from the carts helped prevent medication errors. The IP stated it was also the responsibility of the nurses to check expiration dates and medication labeling as they gave medication. The IP stated expired insulin may not be as effective and put the resident at risk of uncontrolled blood sugar. During a telephone interview on 12/12/25 at 11:46 A.M., the Medical Director (MD) stated that expired medications, such as insulin, were not as effective but otherwise caused no harm to the residents. During an interview on 12/12/25 at 2:28 P.M., the Interim Director of Nursing (IDON) stated that when a vial of insulin or an insulin pen was opened, the nurse was expected to put the open date on the vial or pen. The IDON stated that most insulin was good for 28 days, but there were exceptions. The IDON stated the process for making sure expired insulin or undated insulins were removed from the medication carts included weekly checks by the unit manager. The IDON stated she was the manager for the 100 Hall and 200 Hall and stated she had last checked those carts two weeks prior. The IDON stated she expected the nurses giving the insulin to also check the vials for expiration or lack of dating and stated that undated and expired medications should be discarded. The Administrator was interviewed on 12/13/25 at 10:43 A.M. and stated nurses should not use expired insulin, and if the insulin were undated, the insulin should not be used since the nurse would not know if the insulin had expired. A facility policy titled, Medication Labeling and Storage, dated 2001, indicated, Multi-dose vials that (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	have been opened or accessed (e.g. [exempli gratia, for example], needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.		

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 quaternary ammonium. A facility document titled [Brand Name] Chlorine Test Paper [chemical test strips used to measure the concentration of chlorine in sanitizing solutions] label revealed a copy of the bottle label of the facility's test strips. The label revealed the expiration dates of the facility's chlorine test strips was June 2024, and the label did not indicate the reference range for the correct concentration of chlorine. This violation represents noncompliance investigated under Complaint Number 2612053.		

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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. 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, (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 SSD stated that while Resident #43 had not reported issues of wanting to go to the hospital and being denied, she had overheard a discussion about the resident wanting to transfer to the hospital during a morning meeting. The SSD stated that she had overheard the conversation but was not involved in the discussion. The SSD stated that she had not followed up with Resident #43 about the issue. The SSD stated that if the resident wanted to go to the hospital, it was their right and if the resident felt they needed to seek healthcare elsewhere, the resident had the right to seek that care. A telephone interview was held with LPN #3 on 12/11/25 at 1:23 P.M. The LPN stated that she remembered Resident #43 requested to go to the hospital twice. She stated that in August 2025, the resident's blood sugar had measured 44. She stated she gave the resident something to eat, the symptoms resolved, and the resident did not request to go to the hospital again. She stated that in September 2025, Resident #43 complained of diarrhea, and she gave the resident medication. She stated she called the PCP, but the PCP did not return the call. LPN #3 stated that while she had not called the PCP many times, his usual reply for any problem was laboratory tests and a drug screen. LPN #3 stated that the times she had been with Resident #43, the resident received adequate treatment in the facility and had not required transfer to the hospital. Attempts were made on 12/11/25 at 1:44 P.M. to call LPN #4, who provided care to the resident when they had the episode with chest pain, and the phone had been disconnected. A telephone interview was held with the PCP on 12/12/25 at 11:41 A.M. The PCP stated that he always gave options to residents of being transferred to the hospital or being treated in the facility. The PCP stated that Resident #43 was able to be treated in the facility as easily as in the hospital, and there was nothing that would have been done in the hospital that could not have been done in the facility. He stated that Resident #43 frequently became frustrated and wanted to go to the hospital, and he referred to Resident #43 as a frequent flier that liked to go to the ER for pain medication. The PCP stated that if Resident #43 had transferred to the hospital in August 2025, September 2025, or October 2025, the hospital would have just sent the resident back to the facility, citing that he knew that because he was an ER physician. The PCP stated that he was aware Resident #43 had a cardiac history but stated that the resident's cardiac problems had not been recent. The PCP stated that Resident #43 saw several counselors, and nothing was going to make the resident happy. Resident #43 was interviewed on 12/12/25 at 2:01 P.M. The resident stated that their blood sugar had been low, and while the blood sugar rose after getting the sandwich, there had been difficulty keeping the blood sugar at a normal level. The resident stated the chest pain in October had radiated to the left arm and added they did not appreciate the PCP telling the nurse there was no cardiac history. Resident #43 stated that even with the symptoms temporarily resolving in August 2025, September 2025, and October 2025, they still would have wanted to be transferred to the hospital. The Interim Director of Nursing (IDON) was interviewed on 12/12/25 at 2:28 P.M. The IDON stated that Resident #43 had the right to be sent to the hospital if requested, even if the PCP refused. The IDON stated that even though Resident #43's symptoms had been resolved, if the resident wanted to go to the hospital, the staff should have complied with the resident's request. The Administrator was interviewed on 12/12/25 at 4:43 P.M. The Administrator stated that when a resident requested to be sent to the hospital, she expected the staff to assess the resident, reach out to the PCP, and if the resident still wanted to go to the hospital, they had the right to be transferred to the hospital. She stated that when Resident #43 wanted to go to the hospital, the resident should have been allowed to go. A facility (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	policy titled, Resident Rights, revised February 2021, indicated, 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to, which included, e. self-determination; f. communication with and access to people and service, both inside and outside the facility; and s. choose an attending physician and participate in decision-making regarding his or her care. This deficiency represents noncompliance investigated under Complaint Number 2656134.		

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

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **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. 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. 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. 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. 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. 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. 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. 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 (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	out. She stated that the Administrator was the Abuse Coordinator. 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. 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. The resident's record revealed no evidence that the allegations were reported to the SSA. 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. 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. 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. Resident #43's Care Plan Report revealed no documentation that indicated Resident #43 fabricated stories about staff. 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. The resident's allegation was reported to the Administrator on 09/29/25 at 11:45 A.M. Upon returning to the facility on [DATE], a surveyor request was made for all the allegations of abuse (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that were reported to the SSA. There was no report for the allegation that Resident #43 made against CNA #18. 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. 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. 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. 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. 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. 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. 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 (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notice indicated that the resident was being discharged to either their home or a homeless shelter. Resident #78's record revealed no evidence of the resident threatening another resident being reported to the SSA. 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. 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. 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. 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. This deficiency represents noncompliance investigated under Master Complaint Number 2688424.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, record review, facility document review, and interview, the facility failed to thoroughly investigate allegations of abuse. 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. 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. 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. A handwritten statement from Certified Nursing Assistant (CNA) #11, dated 12/07/25, indicated that on 12/06/25, a coworker from a contracted staffing agency complained about a nurse being rude. The statement indicated that the staff member kept talking about it just about all day and started talking about the nurse abusing someone. The facility's investigation documents revealed no evidence of Resident #69 or any other residents being immediately interviewed regarding RN #10's treatment of them, no evidence of RN #10 being suspended immediately pending investigation following the allegation, and no evidence of the resident being immediately assessed following the allegation. During a telephone interview on 12/10/25 at 10:34 A.M., 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. 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. 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. 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 (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. She stated that the IDON told her to assess the resident and make sure the resident was okay. She stated that she asked the resident if they were in any pain and she was able to see the resident's legs but did not document the assessment. She stated that CNA #11 went into Resident #69's room with her for the rest of the day. 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 reported to her that the CNA heard Resident #69 state that RN #10 was rude. She stated that she interviewed the resident on 12/08/2025. She stated that she conducted the interview because RN #10 stated that Resident #69 was saying that the RN spilled water on the resident. She stated she did not document the interview or ask specifically about the incident. She stated that her interview consisted of asking the resident how the resident's day was. She stated that she also obtained statements from RN #10, CNA #11, and a housekeeper. 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 when she investigated the allegations, she did not find abuse. She stated that she conducted an investigation because CNA #11 wrote in her statement that CNA #9 was stating that a nurse abused a resident. She stated that she did not have documentation of interviews with other residents. The IDON stated that the Unit Manager conducted the interviews with other residents. She stated that Resident #69 was protected because she told CNA #11 to be with RN #10 anytime she needed to give medications to Resident #69 and because she (the IDON) was on the phone with the staff throughout the day. During a follow-up interview on 12/11/25 at 8:42 A.M., CNA #9 stated that the IDON told her that she was taking her (CNA #9) off the schedule to complete an investigation. During an interview on 12/11/25 at 8:54 A.M., the Unit Manager/Infection Preventionist (UM/IP) stated that he found out on 12/08/25 that there was agency staff that felt threatened by a nurse, and that the nurse spilled water on a resident. He stated that he talked to three residents, but they were not interviews; he just asked them how their weekend was, and he did not document the conversations. 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 on 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."She stated that the IDON should have asked in three different ways how it happened. She stated that protecting a resident from abuse would not have included being on the phone. She stated that if an employee was the perpetrator, they should be suspended. She stated that she was not aware of statements obtained from the three employees. She reviewed CNA #11's statement and stated that there should have been an immediate investigation. During an interview on 12/13/25 at 10:38 A.M., the IDON stated that her expectation for conducting an investigation included immediately suspending parties involved; interviewing whoever reported the (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	allegation; start providing education; interview all staff and all residents; and notify family, the Administrator, and the doctor. During an interview on 12/13/2025 at 10:38 AM, the Administrator stated that her expectation for conducting an investigation into abuse allegations included assigning tasks to team members and the investigation being completed immediately. She stated that she expected residents to be kept in a safe manner, staff suspended, authorities called if needed, and the incident to be reported up the corporate chain. Per the Administrator, interviews should be conducted with parties involved, residents involved, staff working in that unit, and possibly dietary, housekeeping, therapy, or respiratory staff. The Administrator stated that assessments should be completed, care plans updated, and hospital records reviewed, if helpful. During an interview on 12/13/25 at 12:59 P.M., the IDON stated that when she assigned CNA #11 to be with RN #10, it was only for Resident #69. She stated that working in pairs was not required when the RN worked with the other residents on the unit. 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. 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. Resident #43's Care Plan Report revealed no documentation that indicated Resident #43 fabricated stories about staff. 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. The resident's allegation was reported to the Administrator on 09/29/25 at 11:45 A.M. Upon returning to the facility on [DATE], the surveyors requested all the allegations of abuse that were reported to the State Survey Agency (SSA). There was no report or facility investigation for the allegation that Resident #43 made against CNA #18. 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. 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 (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. 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. 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. 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. 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. The IDON was interviewed on 12/10/25 at 3:11 P.M. and stated that when an allegation of abuse was received, there should be an investigation. The IDON stated that the Abuse Coordinator for the facility was the Administrator. 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. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator was interviewed on 12/12/25 at 4:52 P.M. The Administrator stated that there had not been an investigation to see if Resident #78 had threatened any other residents, and she did not interview any staff to see if anyone had information about Resident #78 threatening other residents. A facility policy titled, Abuse, Neglect, and Exploitation, 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, V. Investigation of Alleged Abuse, Neglect and Exploitation included, A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. The policy continued, B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g. [exempli gratia; for example] not tampering or destroying evidence); 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation. The policy further indicated, IV. Protection of Resident included, The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: A. Responding immediately to protect alleged victim and integrity of the investigation. B. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; C. Increased supervision of the alleged victim and residents; D. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator; E. Protection from retaliation F. Providing emotional support and counseling to the resident during and after the investigation, as needed; G. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse. This deficiency represents noncompliance investigated under Master Complaint Number 2688424.		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on facility policy review, record review, and interview, the facility failed to document in the medical record any behaviors to support the reason for an emergency discharge as documented on an Emergency Discharge Notice of Discharge and Discharge Summary, and failed to assist with coordinating after discharge care as outlined in the physician's Discharge Summary. This affected one (#78) of two residents reviewed for discharge requirements. The facility census was 71. Findings include: A facility policy titled, Discharge Planning Policy and Procedure, last reviewed 07/28/2025, revealed, This facility is committed to ensuring that all resident discharges are conducted in a safe, person-centered, and compliant manner in accordance with CMS [Centers for Medicare and Medicaid Services] regulations F627 and F628. Discharges will be planned collaboratively with the resident, their representative, and the interdisciplinary team, with a focus on continuity of care, resident rights, and regulatory compliance. The policy revealed, 5. Post-Discharge Coordination, Arrange for, which included, Home Health service, Meals on Wheels or nutritional support, Transportation, and Durable Medical Equipment (DME). The policy continued, Schedule a follow-up appointment with the resident's provider within 14 days of discharge. An admission Record revealed the facility had admitted Resident #78 on 07/20/2023. 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. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/30/2025, revealed Resident #78 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated that Resident #78 scored 7 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. The MDS indicated that the resident used a wheelchair for ambulation. Per the MDS, the resident was independent with eating but required set-up or clean-up assistance from staff for completion of oral hygiene, toileting hygiene, upper and lower body dressing, donning shoes, and personal hygiene. Per the MDS, the resident required supervision or touching assistance from staff for showering and bathing. The MDS also indicated Resident #78 was independent with going from sitting to lying, standing from a sitting position, and with transfers. The MDS indicated that the resident participated in the MDS assessment and goal setting, with no active discharge planning occurring. The MDS revealed the resident had no desire to speak to anyone about the possibility of leaving the facility and returning to the community. Resident #78's Care Plan Report included a focus area initiated on 07/25/2023, 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 09/28/2025. 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 07/26/2023, 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. The Care Plan report included a focus area initiated 07/26/2023 that indicated that the resident was at risk for emotional, mental, and physical distress due to traumatic life experiences. Undated interventions indicated that psychiatric or counseling services were to be provided as needed. Resident #78's physician Progress Note, dated 09/03/2025, indicated that the resident had anxiety and depression and should be monitored by staff and reported to the provider as needed. An Emergency Discharge Notice of Discharge, dated 09/09/2025, indicated that Resident #78 (continued on next page)		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Resident #78's Discharge Summary, completed on 09/09/2025 by the resident's physician, revealed the resident was discharging home. The Discharge Summary indicated that Resident #78 had been a long-term care resident for assistance with activities of daily living. The Discharge Summary indicated that the reason for discharge was because the resident had been found with firearms. The per the Discharge Summary, the discharge plan indicated that after the resident left the facility, they would receive home therapy, social services staff would follow up for any needs with durable medical equipment, and Resident #78 needed to follow up with a primary care physician. The Discharge Summary indicated that Resident #78 had improved back to their baseline and met goals of therapy at the time of discharge. The Discharge Summary revealed the resident was stable and would follow up with providers in the community and follow the treatment plan. Resident #78's medical record revealed no other documented information about Resident #78 threatening any other residents or having weapons in their room. The Social Services Director (SSD) was interviewed on 12/11/2025 at 11:45 AM. The SSD stated that she was primarily responsible for orchestrating and arranging discharges. The SSD stated that when the facility initiated a discharge, the discharge notice included the reasons for discharge and the name of the place the resident was discharging to, including the address of the location, the phone number of the location, and if applicable, the title of the facility. The SSD stated that any behavioral issues for which the resident was being discharged should be on the resident's care plan and in the nurse's progress notes. The SSD stated Resident #78 was discharged because they had brought air soft rifles and handguns that were lifelike into the facility. The SSD stated that those 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. The SSD stated she did not assist in helping the resident with making any follow-up appointments or providing any other services upon discharge. An interview was held with the Administrator on 12/11/2025 at 12:47 PM. The Administrator stated Resident #78 had no known behaviors prior to 09/09/2025, when it was reported that the resident had taken the debit card of other residents and had guns. The Administrator stated the police were called, and Resident #78's family member came to the facility. The Administrator stated the resident was discharged to a local homeless shelter and had been transported by their family member. A telephone interview was held with Resident #78's primary care provider (PCP) on 12/12/2025 at 11:46 AM. The PCP stated that he found out about Resident #78's discharge when facility staff found knives and air rifles in the resident's room. The PCP stated that the facility contacted him immediately and told him Resident #78 had a list of people they were going after. The PCP stated Resident #78 had been a long-term resident in the facility because they had nowhere else to go. He stated Resident #78 was medically stable, and the discharge was safe. The Administrator was interviewed on 12/12/2025 at 4:52 PM. The Administrator stated that prior to Resident #78's emergency discharge, no other ideas or alternatives were discussed. The Administrator stated that the SSD called the homeless shelter prior to the resident arriving. The Administrator stated she was unaware the Discharge Summary included that the resident would be receiving home health services. The Administrator stated that the resident discharged with a family member, so they were not sure if they went to a homeless shelter or not.		

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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. Based on facility policy review, record review, and interview, the facility failed to ensure a resident's discharge was accurately and thoroughly documented in the medical record. This affected one (#78) of two residents reviewed for discharge requirements. The facility census was 71. Findings include: 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. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/30/25, revealed Resident #78 had a Brief Interview for Mental Status (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. The MDS indicated that the resident used a wheelchair for ambulation. Per the MDS, the resident was independent with eating but required set-up or clean-up assistance from staff for completion of oral hygiene, toileting hygiene, upper and lower body dressing, donning shoes, and personal hygiene. Per the MDS, the resident required supervision or touching assistance from staff for showering and bathing. The MDS also indicated Resident #78 was independent with going from sitting to lying, standing from a sitting position, and with transfers. The MDS indicated that the resident participated in the MDS assessment and goal setting, with no active discharge planning occurring. The MDS revealed the resident had no desire to speak to anyone about the possibility of leaving the facility and returning to the community. 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. The Care Plan report included a focus area initiated 07/26/23 that indicated that the resident was at risk for emotional, mental, and physical distress due to traumatic life experiences. Undated interventions indicated that psychiatric or counseling services were to be provided as needed. Resident #78's physician Progress Note, dated 09/03/25, indicated that the resident had anxiety and depression and should be monitored by staff and reported to the provider as needed. An Emergency Discharge 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. Resident #78's Discharge Summary, completed on 09/09/25 by the resident's physician, revealed the resident was discharging home (in contrast with what the discharge notice indicated). The Discharge Summary indicated that Resident #78 had been a long-term care resident for assistance with activities of daily living (ADLs). The Discharge Summary indicated that the reason for discharge was because the resident had been found with firearms (in contrast with what the discharge notice indicated). Per the Discharge Summary, the discharge plan indicated that after the resident left the (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility, they would receive home therapy, social services staff would follow up for any needs with durable medical equipment (DME), and Resident #78 needed to follow up with a primary care physician (PCP). The Discharge Summary indicated that Resident #78 had improved back to their baseline and met goals of therapy at the time of discharge. The Discharge Summary revealed the resident was stable and would follow up with providers in the community and follow the treatment plan. The Discharge Summary did not indicate that a homeless shelter was a possible location the resident was being discharged to and also did not list the full reason the resident was discharged according to the Emergency Discharge Notice of Discharge. Resident #78's Progress Notes revealed a note, dated 09/10/25 at 10:23 A.M., that revealed that Resident #78 had been discharged the prior day. The note indicated that Resident #78 had been provided with information about homeless shelters and food banks. The Social Services Director (SSD) was interviewed on 12/11/25 at 11:45 A.M. The SSD stated that she was primarily responsible for orchestrating and arranging discharges. The SSD stated Resident #78 was discharged because they had brought air soft rifles and handguns that were lifelike into the facility. The SSD stated that those 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. The SSD stated she did not assist in helping the resident with making any follow-up appointments or providing any other services upon discharge. An interview was held with the Administrator on 12/11/25 at 12:47 P.M. The Administrator stated Resident #78 had no known behaviors prior to 09/09/25, when it was reported that the resident had taken the debit card of other residents and had guns. The Administrator stated the police were called, and Resident #78's family member came to the facility. The Administrator stated the resident was discharged to a local homeless shelter and had been transported by their family member. A telephone interview was held with Resident #78's PCP on 12/12/25 at 11:46 A.M. The PCP stated that he found out about Resident #78's discharge when facility staff found knives and air rifles in the resident's room. The PCP stated that the facility contacted him immediately and told him Resident #78 had a list of people they were going after. The PCP stated Resident #78 had been a long-term resident in the facility because they had nowhere else to go. He stated Resident #78 was medically stable, and the discharge was safe. The Administrator was interviewed on 12/12/25 at 4:52 P.M. The Administrator stated the SSD called the homeless shelter prior to the resident arriving, but she was unsure what the SSD had told the homeless shelter. The Administrator stated she was unaware the Discharge Summary included that the resident would be receiving home health services. The Administrator stated the best practice was to have the nurses document what time the resident left, who Resident #78 left with, and where the resident was going. The Administrator stated that the resident discharged with a family member, so they were not sure if they went to a homeless shelter or not. A facility policy titled, Discharge Planning Policy and Procedure, last reviewed 07/28/25, revealed, This facility is committed to ensuring that all resident discharges are conducted in a safe, person-centered, and compliant manner in accordance with CMS [Centers for Medicare and Medicaid Services] regulations F627 and F628. Discharges will be planned collaboratively with the resident, their representative, and the interdisciplinary team, with a focus on continuity of care, resident rights, and regulatory compliance. The policy revealed, 4. Discharge Process and Communication (F628) included, Complete a Discharge Summary including, which included, Recap [Recapitulation] of care and services, Resident's status at discharge, and Post-discharge care instructions.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, record review, and facility policy review, the facility failed to develop individualized resident-centered care plans with measurable objectives for two (#3 and #61) of 49 residents whose care plans were reviewed. The facility census was 71. Findings include: 1. An admission Record revealed the facility admitted Resident #3 on 07/12/24. According to the admission Record, Resident #3 had a medical history that included diagnoses of cerebral infarction (stroke) and osteoarthritis. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/03/25, revealed Resident #3 had severe impairment in cognitive skills for daily decision-making and had a short-term and long-term memory problem per a staff assessment of mental status (SAMS). The MDS indicated Resident #3 had no rejection of care. The MDS indicated Resident #3 had functional limitation in range of motion with impairment on one upper extremity and one lower extremity. The MDS revealed Resident #3 was dependent on staff for completion of all activities of daily living (ADLs), except for eating, and was dependent on staff for all mobility. Resident #3's Care Plan Report included a focus area, initiated 07/25/24, that indicated the resident had osteoarthritis and scoliosis. Interventions directed staff to monitor, document, and report contracture formation and joint changes and to use supportive devices such as splints as recommended by occupational therapy. The Care Plan Report was not individualized for Resident #3 and did not include when the resident was to wear the splint or documentation about the resident's contracture including the contracture location. Resident #3's Order Summary Report, that included active orders as of 12/08/25, revealed, Trialng R [right] hand Splint with therapy for 2 hours, dated 06/16/25. Resident #3's Occupational Therapy [OT] Discharge Summary, with dates of service from 11/19/24 through 06/16/25, indicated the resident would tolerate a splint to the right hand with a schedule to be determined by the patient's tolerance with a time of two hours at discharge, 06/16/25. The OT Discharge Summary indicated the resident/staff would demonstrate 100% compliance/competence with the splint wearing schedule. An observation made on 09/29/25 at 9:37 A.M. revealed Resident #3's right hand was contracted with the resident's fingers resting on palm of the resident's hand. The observation revealed no devices were seen in Resident #3's hand to protect the resident's palm. The Interim Director of Nursing (IDON) was interviewed on 12/12/25 at 2:28 P.M. and stated she expected Resident #3's contractures and interventions for contracture management to be care planned. The MDS Coordinator (MDSC) was interviewed on 12/13/25 at 8:54 A.M. and stated that when developing the care plan, she reviewed physician's orders for devices such as hand rolls or splints. The MDSC reviewed Resident #3's care plan and stated she had omitted the care plan for the contractures and the splints. The Administrator was interviewed on 12/13/25 at 10:45 A.M. and stated she expected the contractures and contracture management to be included in the resident's care plan. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. An admission Record revealed the facility admitted Resident #61 on 09/04/25. According to the admission Record, the resident had a medical history that included diagnoses of acute chronic diastolic (congestive) heart failure, chronic obstructive pulmonary disease, and asthma. An admission (MDS, with an ARD of 09/11/25, revealed Resident #61 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident was not a current tobacco user. Resident #61's Care Plan Report did not include a focus area for smoking. Resident #61's Smoking Assessment, completed 12/04/25, indicated the resident was independent, smoked five to ten times a day, and could light their own cigarette. An observation on 12/10/25 at 1:55 P.M. revealed Resident #61 lighting a cigarette in the smoking courtyard. During an interview on 12/12/25 at 10:59 A.M., the Infection Preventionist (IP), who was also a unit manager, stated Resident #61 should have had a care plan for smoking. During an interview on 12/12/25 at 1:52 P.M., the IDON stated care plans were required for residents who smoked. The IDON stated Resident #61 should have had a smoking care plan and did not have one. During a follow-up interview on 12/12/25 at 2:17 P.M, the IDON stated her expectation for smoking care plans was that they were to be initiated upon admission and quarterly. During an interview on 12/12/25 at 4:37 P.M., the Administrator stated her expectation for development of a smoking care plan was upon admission or upon discovery the resident was a smoker. A facility policy titled, Care Plan Revisions Upon Status Change, reviewed 03/06/25, indicated, Care plans will be modified as needed by the MDS [Minimum Data Set] Coordinator or other designated staff member.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interview, observation, record review, and facility policy review, the facility failed to trim and clean the fingernails for one (#8) of three residents reviewed for activities of daily living (ADLs). The facility census was 71. Findings include: An admission Record revealed the facility admitted Resident #8 on 12/22/09 and most recently readmitted the resident on 05/29/21. According to the admission Record, the resident had a medical history that included multiple sclerosis, type II diabetes mellitus, the need for assistance with personal care, and a contracture of the left hand. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/04/25, revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of three, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #8 was dependent upon staff for the completion of personal hygiene. Resident #8's Care Plan Report, included a focus area initiated 10/23/23, that indicated Resident #8 had a deficit in self-care related to multiple sclerosis. An undated intervention directed staff to keep the resident's fingernails short and clean. During an observation on 09/29/25 at 9:54 A.M., Resident #8's fingernails extended approximately one inch beyond the tip of their fingers. Resident #8 stated staff had not offered to trim their nails but stated their fingernails needed to be trimmed. During an observation on 09/30/25 at 2:58 P.M., Resident #8 was lying in bed. The resident's nails continued to extend beyond the tip of the finger with black matter underneath. During an observation on 12/08/25 at 10:00 A.M., Resident #8 was lying in bed, with their hands bent inward with their fingers pointed toward the palms. The resident's nails extended beyond the tip of the finger approximately one-quarter of an inch, with black matter under the nails. During an interview on 12/09/25 at 11:23 A.M., Certified Nursing Assistant (CNA) #12 stated the CNAs were responsible for clipping and cleaning nails and added if a resident had diabetes mellitus (DM) then the nurse was responsible for trimming resident's nails. During an interview on 12/09/25 at 2:50 P.M., CNA #13 stated that the CNAs were responsible for cleaning residents' nails, and if a resident had DM, then the nurse was responsible for trimming nails. During an interview on 12/11/25 at 10:48 A.M., CNA #12 stated he had cared for Resident #8 on 12/09/25 and had taken the resident to church services. CNA #12 stated that he had seen the resident's nails and stated they needed to be cut, but since the resident had diabetes, he was not allowed to trim the nails. He stated he had not reported to the nurse that Resident #8's fingernails needed to be trimmed. He stated he had been rushing that day and just had not told the nurse. During an interview on 12/11/25 at 11:09 A.M., CNA #14, who was assigned to care for Resident #8 on 12/11/25, stated she noticed the resident's nails were long and needed to be trimmed but if the resident had diabetes, she could not cut the nails. CNA #14 stated she had not reported the resident's long nails to anyone and stated she was unaware she was to report long nails to the nurse. During an observation on 12/12/25 at 1:20 P.M., Resident #8 was sitting upright in a wheelchair by their bed. The resident's nails continued to extend approximately one-quarter to one-half inch past the tip of the finger, with black matter underneath. During an interview on 12/12/25 at 1:30 P.M., Licensed Practical Nurse (LPN) #8, who was assigned to care for Resident #8, stated she had received no reports that Resident #8's fingernails needed to be cleaned and trimmed. LPN #8 observed the resident's nails and stated that the nails needed to be cleaned and trimmed. During an interview on 12/12/25 at 2:28 P.M., the Interim Director of Nursing (IDON) stated the nursing staff were responsible for clipping residents' nails and added if a resident had a diagnosis of DM, then it was the responsibility of the nurses. The IDON stated she expected the CNAs to alert the nurses if residents' nails needed trimming. The IDON stated Resident #8 had DM, so the nurse would be responsible for trimming their fingernails. The Administrator was interviewed on 12/13/25 at 10:45 A.M. and stated she expected fingernails to be kept clean and trimmed. The Administrator stated that if the CNA was unable to trim nails due to a diagnosis of DM, she expected the CNA to tell the nurse so the nails could be trimmed. A facility policy titled, Activities of Daily Living (ADLs), Supporting, revised March 2018, indicated, Residents (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.		

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 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. Based on interview, observation, record review, and facility policy review, the facility failed to place a splint or handroll into residents contracted hands as ordered by the physician. This affected two (#3 #8) of three residents reviewed for contractures. The facility census was 71. Findings include: 1. An admission Record revealed the facility admitted Resident #3 on 07/12/24. According to the admission Record, Resident #3 had a medical history that included cerebral infarction (stroke) and osteoarthritis. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/03/25, revealed Resident #3 had severe impairment in cognitive skills for daily decision-making and had short-term and long-term memory problems per a Staff Assessment of Mental Status (SAMS). The MDS indicated Resident #3 had not rejected care during the assessment's lookback period. The MDS indicated the resident had functional limitations in range of motion on one upper extremity and one lower extremity. The MDS revealed Resident #3 was dependent on staff for completion of all activities of daily living (ADLs), except for eating, and was dependent on staff for all mobility. Resident #3's Care Plan Report had no documentation about the resident's contractures and no interventions to prevent the contracture from worsening. Further review revealed no information on splint usage, including when the resident was to wear the splint. The Care Plan Report included a focus area initiated on 07/25/24, that indicated the resident had osteoarthritis. Interventions directed staff to use supportive devices such as braces, canes, crutches, and splints as recommended by occupational therapy (OT). An Occupational Therapy OT Discharge Summary, dated 06/16/25 indicated that on 06/16/25 Resident #3 met the goal of tolerating a splint to their right hand with the schedule to be determined by the resident's tolerance. The discharge summary revealed that on discharge, the resident was tolerating the splint for two hours per day. The discharge summary indicated that the long-term goal was that the patient and staff would demonstrate 100% compliance/competence with the splint-wearing schedule. The discharge summary revealed that on discharge, staff and resident compliance with the schedule was 50%. Resident #3's Order Summary Report with active orders as of 12/08/25, revealed an order dated 06/16/25, for trialing a right-hand splint with therapy for two hours. Resident #3's November 2025 and December 2025 Medication Administration Record [MAR] indicated there were no entries that documented when Resident #3's splint had been donned and doffed. During an observation on 09/29/25 at 9:37 A.M., Resident #3's right hand was contracted, with the resident's fingers resting on their palm. During an observation on 09/30/25 at 2:50 P.M., Resident #3 was lying in bed. The splint for Resident #3 was lying on the bookcase. During an observation on 12/09/25 at 10:31 A.M., Resident #3 was lying in bed with their eyes closed. The resident's splint was lying on the overbed table to the left of the resident's bed. During an observation on 12/11/25 at 10:38 A.M., Resident #3 was lying in bed with their eyes closed, sitting in an upright position. The resident's splint was not on the resident's hand, and no rolled cloths had been placed in the resident's clenched fists. During an interview on 12/09/25 at 11:23 A.M., Certified Nursing Assistant (CNA) #12 stated the therapy department educated the CNAs on how to apply splints used by residents and how long to leave the splints on the residents. CNA #12 stated there were no residents in his hall, the hall where Resident #3 lived, that refused to have their splints or hand rolls applied. During an interview on 12/09/25 at 2:50 P.M., CNA #13 stated that the CNAs were responsible for placing splints and rolled wash cloths and towels in residents' hands. CNA #13 stated either the nurse, or the therapy department let the CNA know how to apply the splint and how long to leave splints on. CNA #13 stated there was no one in the hall where she worked that refused to have their splints applied. During an interview on 12/11/25 at 10:54 A.M., CNA #12 stated the therapy department had not given instruction on how to place Resident #3's splints, and he was unsure when the resident was scheduled to wear the splint. CNA #12 stated that the instruction for Resident #3's splint should be found in the bedside table. CNA #12 stated that on 12/09/25 he had not placed Resident #3's splint on because the resident had been in bed all day. During an interview on (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/11/25 at 11:14 A.M., CNA #14 stated she was unaware Resident #3 had a splint and added she had received no education on placing the resident's splint. CNA #14 confirmed Resident #3 had a contracted hand and stated she had not placed a rolled cloth in the resident's hand because she had not been instructed to place anything in the resident's hand. During a concurrent observation, CNA #14 went to the resident's room to look for an instruction guide for the resident's splint and saw Resident #3's splint on the nightstand. CNA #14 stated she had not seen the resident wear the splint and was unable to find information about the splint in the resident's room. During an interview on 12/11/25 at 3:15 P.M., the Rehabilitation Manager (RM) stated education for contracture management including when to apply a splint was done verbally, then staff signed an attendance document. The RM stated that the use of splints was important to prevent skin breakdown or decline of the contracture. The RM confirmed that Resident #3 had a right-hand splint. He stated he had reviewed the educational documentation for Resident #3 and the CNAs that signed the document no longer worked in the facility. The RM stated that when Resident #3 had been discharged from OT on 06/16/25, donning the splint became the responsibility of the nursing department, and the nursing department was responsible for making sure staff complied with the application of the splint. The RM stated he had received no reports from staff that indicated Resident #3 refused to wear the splint. During a telephone interview on 12/12/25 at 11:46 P.M., the Medical Director (MD) stated he expected staff to follow the physician's order. He stated that the continued non-use of splints in contracted hands could potentially make the contractures worse. During an interview on 12/12/25 at 2:28 P.M., the Interim Director of Nursing (IDON) stated that when a resident had an order for a splint, she expected staff to follow the order and place the splint on the resident. The IDON stated that if the splint was not used per orders, the contracture may worsen. The Administrator was interviewed on 12/13/25 at 10:45 A.M. and stated she expected the physician's orders for Resident #3's splint to be followed to prevent skin breakdown and to keep the contracture from getting worse. 2. An admission Record revealed the facility admitted Resident #8 on 12/22/09 and most recently readmitted the resident on 05/29/21. According to the admission Record, the resident had a medical history that included multiple sclerosis, type II diabetes mellitus, the need for assistance with personal care, and a contracture of the left hand. A quarterly MDS, with an ARD of 10/04/25, revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #8 was dependent upon staff for the completion of personal hygiene. Resident #8's Care Plan Report, included a focus area initiated 10/23/23, that indicated Resident #8 had a self-care performance deficit related to multiple sclerosis. Interventions directed staff to apply a left-hand towel roll or hand splint, and staff were to encourage range of motion during activities. Resident #8's Order Summary Report, with active orders as of 12/08/25, revealed an order dated 02/27/24, for a left palm roll to be placed in the morning while out of bed and to be taken off at night when in bed. Resident #8's November 2025 and December 2025 Medication Administration Record [MAR] revealed there was no documentation of the donning or doffing of the left palm roll. A Kardex (a care plan accessed by the CNAs instructing them on how to care for a resident) indicated Resident #8 was to have a left-hand towel roll or a hand splint. During an observation on 09/29/25 at 9:30 A.M., Resident #8's left hand was contracted, with the resident's pointer finger sticking straight out toward the thumb and other fingers curved toward the palm. Nothing was seen in the palm of the resident's hand. During an observation on 09/30/25 at 2:58 P.M., Resident #8 was lying in bed with no washcloth or splint in the resident's hand. The resident was unable to say if they had been up in the wheelchair that day or if the splint had been applied. During an observation on 12/08/25 at 10:00 A.M., Resident #8 was lying in bed with both hands bent inward with their fingers pointed toward the palms. There was nothing in the resident's hands to prevent the fingertips from touching the resident's palms. During an observation on 12/09/25 at 11:08 A.M., Resident #8 was sitting in a geriatric chair in the chapel for church service. The resident had no towel roll in their left hand as directed by physician's orders. During an interview on 12/09/2025 at 11:23 A.M., CNA #12 stated the therapy department (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	educated the CNAs on how to apply handrolls and stated there were no residents on Resident #8's hall that refused to have their hand rolls applied. CNA #12 stated there should be an instructional sheet in the resident's room directing how and when to apply the hand rolls. During an observation on 12/11/25 at 10:36 A.M., Resident #8 was sitting in a wheelchair next to the bed. There was no rolled washcloth, towel, or splint in Resident #8's hands. During a follow-up interview on 12/11/25 at 10:48 A.M., CNA #12 stated Resident #8 was to wear the handroll when they were up, but he was not entirely sure what the order for the handroll included. He stated that on 12/09/25 when Resident #8 had been to the church service, he had not applied the resident's handroll and stated he had forgotten. During an interview on 12/11/25 at 11:09 A.M., CNA #14 stated Resident #8 was out of bed at 8:00 A.M. CNA #14 stated she had worked in the facility for six months and had not seen anything in the resident's hand. CNA #14 stated she had not placed anything in Resident #8's hand because she was unaware she was to place anything in the resident's hands. During an interview on 12/11/25 at 3:15 P.M., the RM stated that the order for Resident #8's handroll was placed in February 2024 and the resident was to wear the left palm roll-up while out of bed. The RM defined a left palm roll-up as a washcloth placed in the resident's hand. The RM reviewed the treatment notes for Resident #8 and stated Resident #8's hand splint no longer fit, and a hand roll was recommended. The RM stated measuring Resident #8's contractures to see if the contractures were worse would not be possible since the OT was only in the building two days a week, and an order for an evaluation would be needed before the OT could measure. During a telephone interview on 12/12/25 at 11:46 A.M., the MD stated he expected staff to follow physician's orders. The MD stated that continued non-use of hand rolls or splints in contracted hands could potentially make the contracture worse. During an observation on 12/12/25 at 1:20 P.M., Resident #8 was sitting upright in a wheelchair by their bed. There was not a handroll in the resident's hand. During a concurrent interview, Licensed Practical Nurse (LPN) #8, who was assigned to care for Resident #8 on 12/12/25, stated she was aware that Resident #8 had orders for handrolls and stated they were to be in the resident's hands when the resident was out of bed. LPN #8 went to the resident's room and validated there were no handrolls in the resident's hands. She instructed CNA #14 to get hand rolls and place them in Resident #8's hands, and the CNA replied that therapy had to place the handrolls. During an interview on 12/12/25 at 2:28 P.M., the IDON stated that when a resident had an order for a handroll, she expected staff to follow the order and place the handroll. The IDON stated that if the handroll was not used per orders, the contracture could get worse. The IDON stated Resident #8's hand roll should be documented on the MAR. The Administrator was interviewed on 12/13/25 at 10:45 A.M. and stated she expected the staff to follow the physician's orders and place the handrolls in Resident #8's hand. She stated that not using the hand roll could lead to skin breakdown and worsening of the contracture. A facility policy titled, Functional Impairment-Clinical Protocol, revised September 2012, revealed the section titled, Cause Identification, included, 5. The physician and staff will evaluate the resident for complications secondary to functional decline and/or immobility, such as: f. muscle atrophy/contractures. The policy revealed the section titled, Treatment/Management, indicated, 2. In conjunction with the physician and staff, therapists will propose a rehabilitation or restorative care plan that provides an appropriate intensity, frequency, and duration of interventions to help achieve anticipated goals and expected outcomes efficiently using available resources		

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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. Based on observation, interview, record review, facility policy review, and product operation manuals, the facility failed to ensure resident weight settings were correct on low air loss mattresses. This affected two (#2 and #57) of two residents reviewed for pressure ulcer management. The facility census was 71. Findings include: 1. An admission Record indicated the facility originally admitted Resident #2 on 07/29/15 and readmitted the resident on 03/06/23. According to the admission Record, the resident had a medical history that included diagnoses of congestive heart failure and unspecified head injury. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/12/25, revealed Resident #2 had severe impairment in cognitive skills for daily decision-making and had a short-term and long-term memory problem per a staff assessment of mental status (SAMS). The MDS indicated Resident #2 was dependent with activities of daily living (ADLs) and had functional limitations of both upper and lower extremities. The MDS indicated Resident #2 was at risk for pressure ulcers, had no current unhealed pressure ulcers, and was on a pressure-reducing device for the bed. Resident #2's Order Summary Report, dated 01/02/25, indicated a physician's order for low air loss mattress. Resident #2's Care Plan Report, included a focus area, initiated 10/23/23, that indicated the resident had ADLs self-care performance deficit. Interventions included the use of a pressure reducing perimeter mattress. Resident #2's Treatment Administration Record (TAR), dated September 2025, indicated the resident was on a low air loss mattress every shift. Resident #2's Weight Summary, dated 09/16/25, indicated the resident's weight was 173.4 pounds (lbs.). An observation on 09/29/25 at 10:21 A.M. revealed Resident #2's low air loss mattress setting dial was set at 280 lbs. Resident #2's, TAR, dated December 2025, indicated the resident was on a low air loss mattress every shift. Resident #2's Weight Summary, dated 12/02/25, indicated the resident's weight was 174.2 lbs. An observation on 12/08/25 at 10:09 A.M. revealed Resident #2 asleep and lying on their bed with the low air loss mattress setting dial pointing between 240-280 lbs. An observation on 12/09/25 at 9:39 A.M. revealed Resident #2 awake and lying on their bed with the low air loss mattress setting dial pointing between 240-280 lbs. An observation on 12/10/25 at 3:21 P.M. revealed Resident #2 asleep and lying on their bed with the low air loss mattress setting dial pointing between 240-280 lbs. A concurrent observation and interview, on 12/11/25 at 2:08 P.M., revealed Resident #2 was awake and lying on their bed with the low air loss mattress setting dial pointing between 240-280 lbs. Licensed Practical Nurse (LPN) #15 stated the low air loss mattress setting was set-up by the mattress company while the nurses ensured the low air loss mattress pump was turned on and secured to the bed frame. During a telephone interview on 12/11/25 at 10:49 P.M., LPN #16 stated the low air loss mattress setting was set up by the mattress company, and the nurses ensured the low air loss mattress pump was plugged in and the weight settings were correct. During a concurrent observation and interview on 12/12/25 at 1:36 P.M., LPN #17 stated she did not touch the low air loss mattress setting because whoever delivered the low air loss mattress placed the setting. 2. An admission Record indicated the facility admitted Resident #57 on 01/17/22. According to the admission Record, the resident had a medical history that included diagnoses of acute respiratory failure, severe protein-calorie malnutrition, muscle wasting and atrophy, and adult failure to thrive. A quarterly MDS, with an ARD of 11/06/25, revealed Resident #57 had a Brief Interview for Mental Status (BIMS) score of seven, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #57 was dependent with ADLs except for eating for which they required setup or clean-up assistance. The MDS indicated Resident #57 was at risk for pressure ulcers, had no current unhealed pressure ulcer, and was on a pressure-reducing device for bed. Resident #57's Order Summary Report, dated 04/07/2025, indicated a physician's order for a low air loss mattress. Resident #57's Care Plan Report included a focus area, initiated 01/25/24, that indicated the resident was at risk for skin breakdown related to decreased mobility, malnutrition, pain, and incontinence. Interventions included the use of a low air loss mattress. Resident #57's TAR, dated (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	September 2025, indicated the resident was on a low air loss mattress every shift. Resident #57's Weight Summary, dated 09/11/25, indicated the resident's weight was 90.2 pounds (lbs.). An observation on 09/29/25 at 11:13 A.M. revealed Resident #57's low air loss mattress setting dial was set at 120 lbs. Resident #57's TAR, dated December 2025, indicated the resident was on a low air loss mattress every shift. Resident #57's Weight Summary, dated 12/02/25, indicated the resident's weight was 74.8 lbs. An observation on 12/08/25 at 10:40 A.M. revealed Resident #57 was lying on their bed, with their low air loss mattress setting dial pointing at 120 lbs. An observation on 12/10/25 at 3:18 P.M. revealed Resident #57 was asleep on their bed with their low air loss mattress setting dial set at 120 lbs. An observation on 12/11/25 at 8:59 A.M. revealed Resident #57 was awake on their bed with their low air loss mattress setting dial pointing at 120 lbs. A concurrent observation and interview on 12/11/25 at 1:45 P.M., LPN #17 stated the low air loss mattress was necessary for prevention of skin breakdown. During an interview on 12/12/25 at 2:51 P.M., the Infection Preventionist (IP), who was also a unit manager, stated the low air loss mattress setting was set by the mattress company technician based on the resident's weight, and the facility only made a change if there were issues with the airflow. During an interview on 12/13/25 at 9:35 A.M., the Interim Director of Nursing (IDON) stated the nurses were to ensure the low air loss mattress pump was set at the correct dial setting for the resident's weight to help reduce the risk of getting a pressure ulcer and to prevent damage to the resident's skin. During an interview on 12/13/25 at 10:50 A.M., the Administrator stated the facility should follow the manufacturer's instructions on the use of low air loss mattresses. The Administrator stated the mattress setting was adjusted based on the resident's weight to prevent skin breakdown. A facility policy titled, Pressure Ulcers/Injuries Overview, revised 04/01/22, indicated, Prevention of Pressure Ulcers/Injuries - all facility mattresses are pressure reducing mattresses if we identify a pressure ulcer/injury we go to a low air loss mattress. An undated document titled, Operation Manual for [Brand Name] 2000, [pump and mattress overlay system] indicated, [Brand Name] 2000 pump and overlay system [item #] is indicated for the prevention and treatment of any and all stage pressure ulcers when used in conjunction with a comprehensive pressure ulcer management program. The section Overlay indicated, The [Brand Name] 2000 System comes with a 5' [inch] air cell overlay that provides low air loss, alternation and static pressure redistribution therapy. The section Product Functions indicated, Pressure-Adjust Knob (2) - Determine the patient's weight and set the control knob to that weight setting on the control unit. An undated document titled, Operation Manual for [Brand Name] 3000/3500/3600 [pump and mattress overlay system], indicated, [Brand Name] 3000 pump and mattress system, is indicated for the prevention and treatment of any and all stage pressure ulcers when used in conjunction with a comprehensive pressure ulcer management program. The section Mattress indicated, The [Brand Name] 3000/3500/36000 System comes with an air cell mattress that provides low air loss, alternation and static pressure redistribution therapy. The section Product Functions indicated, Pressure-Adjust Knob (2) - Determine the patient's weight and set the control knob to that weight setting on the control unit.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, record review, observation, and interview, the facility failed to ensure residents did not retain their own lighters according to the facility policy. This affected three (#61, #5, and #58) of four residents reviewed for smoking. The facility census was 71. Findings include: 1. An admission Record revealed the facility admitted Resident #61 on 09/04/25. According to the admission Record, the resident had a medical history that included diagnoses of acute chronic diastolic (congestive) heart failure; chronic obstructive pulmonary disease, unspecified; and unspecified asthma, uncomplicated. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/11/25, revealed Resident #61 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. Resident #61's Care Plan Report revealed no information about the resident smoking. Resident #61's Smoking Assessment, dated 12/04/25, indicated that Resident #61 did not have cognitive loss, visual deficit, or a dexterity problem. The assessment further indicated that the resident was independent, smoked five to ten times a day, and the resident could light their own cigarette. The assessment revealed the resident was provided with the smoking policy, and the plan of care was used to ensure resident was safe while smoking. An admission Record revealed the facility admitted Resident #5 on 02/05/25. According to the admission Record, the resident had a medical history that included a diagnosis of nicotine dependence, unspecified, uncomplicated. A quarterly MDS, with an ARD of 11/12/25, revealed Resident #5 had a BIMS score of 15, which indicated the resident had intact cognition. The MDS indicated that the resident had the ability to understand others with clear comprehension. Resident #5's Care Plan Report included a focus area initiated 02/21/25, that indicated the resident had a potential for injury related to smoking. Undated interventions directed staff to secure cigarettes/lighters at the nurses' station. Resident #5's Smoking Assessment, dated 12/10/25, indicated that Resident #5 did not have cognitive loss, visual deficit, or a dexterity problem. The assessment further indicated that the resident required supervision, smoked two to five times a day, and the resident could light their own cigarette. The assessment revealed the resident was provided the smoking policy, and the plan of care was used to ensure resident was safe while smoking. During an observation on 12/10/25 at 1:54 P.M., Resident #5 pulled a lighter from the resident's bag/pouch, went into the smoke [NAME], and lit a cigarette. At 1:55 P.M., Resident #61 lit a cigarette in the smoking courtyard during a resident smoke break. During an interview on 12/10/25 at 1:58 P.M., the Activity Director (AD) stated she did not light Resident #5's or Resident #61's cigarettes, and she did not know what lighter the residents used. During an observation and interview on 12/10/25 at 2:00 P.M., Resident #5 provided their lighter to the AD. The resident stated they (Resident #5) kept lighters because the resident did not get them back when they gave them to the facility staff. During an interview on 12/10/25 at 2:01 P.M., Resident #61 stated that they (Resident #61) lit the cigarette with the lighter the resident kept in a pouch/bag. 2. An admission Record revealed the facility admitted Resident #58 on 08/26/25. According to the admission Record, the resident had a medical history that included a diagnosis of peripheral vascular disease, unspecified. A significant change MDS, with an ARD of 12/03/25, revealed Resident #58 had a BIMS score of 14, which indicated the resident had intact cognition. The MDS indicated that the resident had the ability to understand others with clear comprehension and was a tobacco user. Resident #58's Care Plan Report included a focus area initiated 08/28/25, that indicated the resident was a smoker. Undated interventions directed staff to notify the charge nurse immediately if it was suspected that the resident had violated the facility smoking policy. Resident #58's Smoking Assessment, dated 11/27/25, indicated Resident #58 did not have cognitive loss, visual deficit, or a dexterity problem. The assessment further indicated that the resident required supervision, smoked two to five times a day, and the resident could light their own cigarette. The assessment revealed the resident was (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided with the smoking policy, and the plan of care was used to ensure resident was safe while smoking. During an observation on 12/09/25 at 1:46 P.M., during a resident smoke break, Resident #58 handed a lighter to another resident so the resident could light a cigarette. Once the cigarette was lit, Resident #58 placed the lighter in the resident's bag. During an interview at the time of the observation, Licensed Practical Nurse (LPN) #19 stated that she saw the other resident light a cigarette with Resident #58's lighter. Resident #58 took the lighter from the resident's bag and gave it to the LPN. During an interview on 12/10/25 at 9:15 A.M., the AD stated Resident #58 had a lighter and refused to give it to the facility staff. During an interview on 12/12/25 at 6:18 P.M., the AD stated Residents #61, #5, and #58 had not given her their lighters to be stored since she started in her position in July 2025 or since their admission, if it was after her start date. During an interview on 12/12/25 at 10:59 A.M., the Unit Manager/Infection Preventionist (UM/IP), stated Residents #61, #5, and #58 should not have had a lighter; activities staff should have had them. The UM/IP stated that at the point the lighter was used outside, it should have been a conversation, confiscation, documentation, and notifications to the Director of Nursing (DON), Medical Director (MD), and Responsible Party (RP). He stated that a resident with a lighter could have lit it near supplemental oxygen, could have burned a room down, or could have lost the lighter, and another resident found it. During an interview on 12/12/25 at 1:52 PM, the Interim Director of Nursing (IDON) stated the facility policy was that smokers were supervised and lighters were stored in a locked cart. She stated that she had not been made aware Resident #5 and Resident #61 had lighters and was not made aware Resident #58 had a lighter until the previous day (12/11/25). She stated that a resident having a lighter was dangerous because it could start a fire. During an interview on 12/12/25 at 2:17 PM, the IDON stated her expectation was for staff to maintain a safe and hazard-free environment. She stated that she expected the facility to store lighters in a locked bin. During an interview on 12/12/2025 at 4:26 P.M., the Administrator stated that the AD and activity aides oversaw the smoking activity. She stated that the process of smoking was to complete an assessment, explain times and facility policy, and the AD met with them. The Administrator stated that she had not been aware Residents #5, #61, or #58 were storing their own lighters. During an interview on 12/12/25 at 4:37 P.M., the Administrator stated her expectation was for the facility to be free of accidents. She stated she expected residents to adhere to the smoking policy and the scheduled times and for residents not to have lighters or matches on them. A facility policy titled, Smoking Policy, revised 01/27/25, indicated, All smoking paraphernalia brought into the facility are to be given to the ACTIVITIES Department or staff NURSE for inventory. Lighters are considered a hazard and should be kept and locked in a safe place at all times.		

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on manufacturer guidelines, observation, and interview, the facility failed to ensure staff sanitized a blood glucose monitor after checking a resident's blood sugar and before placing the blood glucose monitor into the medication cart for further use. This affected one (#8) of two residents observed who had their blood sugar checked during medication administration. The facility census was 71. Findings include: An admission Record revealed the facility admitted Resident #8 on 12/22/09 and most recently readmitted the resident on 05/29/21. According to the admission Record, the resident had a medical history that included a diagnosis of type II diabetes mellitus. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/04/25, revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of three, which indicated the resident had severe cognitive impairment. The MDS indicated that the resident had an active diagnosis of diabetes mellitus. Resident #8's Care Plan Report revealed a focus statement initiated 09/23/14, that indicated the resident had a potential for complications related to diabetes mellitus. Interventions directed staff to monitor and record the resident's blood glucose checks per their physician's orders. Resident #8's Order Summary Report, with active orders as of 12/08/25, revealed an order dated 09/23/24 for blood sugar level checks to be completed every six hours. An observation was made on 12/10/25 beginning at 8:00 A.M. during the morning medication administration. Licensed Practical Nurse (LPN) #1 removed a blood sugar monitor from the medication cart, took the monitor into Resident #8's room, and placed the monitor on the resident's bedside table. After completion of the blood glucose test, LPN #1 took the monitor to the medication cart, placed the monitor initially on top of the cart, and then opened a drawer and placed the blood glucose monitor back into the medication cart and stated that she was ready to test the next resident's blood sugar. During an interview on 12/10/25 at 8:36 A.M., LPN #1 stated that there was no reason she did not sanitize the blood glucose monitor prior to placing the monitor back into the medication cart. During an interview on 12/12/25 at 11:21 A.M., the Unit Manager/Infection Preventionist (UM/IP) stated that the expectation was for the blood glucose monitors to be sanitized between each resident to slow the spread of bacteria or other organisms. The IP stated that cleaning blood glucose monitors was customary practice and not something that just this facility expected. During a telephone interview on 12/12/25 at 11:46 A.M., Resident #8's Primary Care Physician (PCP) stated that it was best practice to clean/sanitize the blood glucose monitor between residents. The Interim Director of Nursing (IDON) was interviewed on 12/12/25 at 2:28 P.M. The IDON stated that she expected the blood glucose monitor to be cleaned between residents and expected the monitor to be cleaned before placing it in the medication cart. The IDON stated that the danger of not cleaning the blood glucose monitor could be the spread of infection. The Administrator was interviewed on 12/13/25 at 10:40 A.M. The Administrator stated that she expected the nurses to follow the facility policy, which directed staff to clean the blood glucose monitor between residents' use. The manufacturer's Cleaning & (and) Disinfecting Guidelines for the blood glucose monitor that was used for Resident #8 indicated that the manufacturer suggested cleaning and disinfecting the monitor between patient use. The instructions revealed, Cleaning and disinfecting can be completed by using a commercially available EPA [Environmental Protection Agency] registered disinfectant detergent or germicidal wipe.		