

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366142	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/10/2025
NAME OF PROVIDER OR SUPPLIER Mill Run Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3399 Mill Run Drive Hilliard, OH 43026	
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 - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record reviews, observations, interviews, review of service invoices, and review of facility policies, the facility failed to ensure residents received care and services in accordance with professional standards of practice and plans of care to meet each resident's individual identified needs. This resulted in Actual harm for one resident (#18) on 03/05/25 at 8:00 A.M. when a power outage occurred in the facility and the generator did not start. Resident #18, who was assessed to have chronic respiratory failure and was dependent on continuous oxygen, was not monitored for respiratory failure during the power outage. This resulted in a hospitalization for Resident #18 when on 03/05/25 at 9:18 A.M., a nurse was alerted that Resident #18 was confused and having a change in condition. Resident #18 was noted to have an oxygen saturation level of 45% oxygenation (A normal oxygen saturation level (SpO2), as measured by a pulse oximeter, is typically between 95% and 100%. Levels below 95% are generally considered low and may indicate a problem like hypoxemia (low blood oxygen) that was unable to be increased. Emergency services were called, and Resident #18 was admitted to the hospital with a diagnosis of acute kidney injury in the setting of hypoxia. This affected one (#18) of one resident reviewed for oxygen usage. Additionally, the facility failed to monitor the duration and characteristics of seizures after episodes for Resident #32, failed to ensure that treatments were completed for edema and to notify the physician of edema for Resident #50, and failed to complete physician ordered ear wax treatments for Resident #20, which placed these residents at risk for the potential for more than minimal harm that was not actual harm. This affected one (#32) of one resident reviewed for change in condition, one (#50) of two residents reviewed for edema, and one (#20) of one resident reviewed for ear treatments respectfully. The facility census was 53 residents. Findings include: 1) Review of Resident #18's medical record revealed Resident #18 was admitted to the facility on [DATE]. Diagnoses included chronic respiratory failure, hypertensive heart disease, chronic kidney disease, and chronic congestive heart failure. Review of Resident #18's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she had a Brief Interview for Mental Status (BIMS) score of 12, indicative of intact cognition. Resident #18 was assessed to be dependent for showering and dependent for mobility. She was assessed as receiving oxygen as a treatment and having respiratory failure. Review of Resident #18's physician orders dated 01/08/25 revealed she was on oxygen via nasal cannula at 2-4 liters per minute. Review of Resident #18's respiratory care plan dated 07/09/24 revealed Resident #18 was at risk of altered respiratory status related to respiratory failure. The goal listed was to have no complications related to being short of breath. Interventions listed were to administer medication as ordered and monitor for effectiveness and side effects, and to administer humidified oxygen at 2-4 liters per minute via nasal cannula or mask continuously as of 01/08/25. Review of Resident #18's oxygen therapy care plan last updated on 02/20/25 revealed Resident #18 was on oxygen therapy related to ineffective gas exchange. Oxygen was ordered as needed but Resident #18 preferred to wear oxygen continuously and needed to wear oxygen to keep oxygen saturation above 90% oxygenation. The goal for Resident #18 was to have no signs of poor oxygen absorption. Interventions included oxygen was to be worn at orders of 2-4 liters of oxygen per minute via nasal cannula or mask continuously. Review of Resident #18's nursing (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 0684 Level of Harm - Actual harm Residents Affected - Few	progress notes authored by Unit Manager #322 revealed Unit Manager #322 was alerted on 03/05/25 at 9:18 A.M. that Resident #18 was twitching in her hand, confused and not acting like herself. Unit Manager #322 noted Resident #18 had been on oxygen via a nasal cannula in her room and her oxygen saturation was dropping. Resident #18 was then changed to a portable oxygen tank for her oxygen delivery. Resident #18's oxygen saturation was documented to be 45% and not increasing. Emergency services were called, and Resident #18 was sent to the hospital. An interview with Resident #18 on 09/02/25 at 11:19 A.M. revealed that earlier in the year, the generator in the building was not working during a facility power failure. Resident #18 revealed that her oxygen concentrator would not work during the power outage, and she was subsequently hospitalized. An interview with Licensed Practical Nurse (LPN) #400 on 09/03/25 at 1:29 P.M. revealed that Resident #18 had been confused on 03/05/25. LPN #400 revealed that the power was out in the morning of 03/05/25 and Resident #18's oxygen saturation was low. Resident #18's oxygen concentrator was unable to operate properly due to the power outage. LPN #400 noted that Resident #18 was not observed to be blue in color; however, Resident #18 was noted to be confused and drifting off in her conversation with the nursing staff. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed that vital signs were last documented on the TAR on 03/02/25 and that no additional monitoring was documented during the power outage on 03/05/25. Review of the oxygen saturation summaries for Resident #18 revealed on 03/05/25, no oxygen saturation monitoring was documented during the power outage on 03/05/25. Review of the transfer to the hospital assessment dated [DATE] revealed Resident #18's most recent vitals included an oxygen saturation level of 97% on 03/03/25 and no oxygen saturation levels were documented on the hospital discharge assessment on 03/05/25. The transfer assessment revealed that Resident #18 was receiving oxygen at 2 liters per minute. Review of the hospital records for Resident #18 for the hospital admission on [DATE] revealed Resident #18 presented from her extended care facility on 03/05/25 with hypoxia after her facility lost power. The hospital records indicated that Emergency Medical Services arrived at the extended care facility, and her oxygen saturation was in the 80% range. Emergency Medical Services used 4 to 6 liters of oxygen per minute to bring Resident #18's oxygen saturation level back into a normal range. The hospital records indicated that reportedly, the extended care facility lost power at 8:00 A.M. and did not have a working backup generator. Resident #18 was reported to be off of her supplemental oxygen for a significant period of time. Resident #18's pulse oxygenation level was 98% upon arrival at the hospital. Resident #18 was noted to have acute kidney injury at the hospital, with a Blood Urea Nitrogen (BUN) level of 77 milligrams per deciliter (mg/dL) [normal range 6-20 mg/dL] on 03/05/25 and a Creatinine level of 3.21 mg/dL (normal range 0.6-1.1 mg/dL) on 03/05/25 in the presence of hypoxia. Hospital records revealed Resident #18 was treated with gentle rehydration (lactated ringers' infusion at 50 milliliters per hour) with significant improvement. The hospital records indicated the pharmacy technician attempted to receive an updated medication list from the facility multiple times, but the pharmacy technician was told that the facility did not have time to talk with the pharmacy technician. An interview with Maintenance Director #285 on 09/03/25 at 4:55 P.M. revealed that on 03/05/25 around 8:00 A.M., the building next door to the facility was having excavation work done, and the excavators accidentally cut the power lines to the facility. Maintenance Director #285 revealed that the generator did not turn on once the power lines were cut. Maintenance Director #285 revealed the generator company was called, and they arrived at the facility within one hour. Further interview revealed that the generator company and Maintenance Director #285 discovered the generator settings were incorrect. Maintenance Director #285 stated he observed the generator settings were set to manual settings, and not on automatic. Maintenance Director #285 revealed that he did not know who set the generator settings to manual. An interview with the Director of Nursing (DON) on 09/04/25 at 9:58 A.M. confirmed that during the two-hour power outage on 03/05/25 from 8:00 A.M. to 10:00 A.M., the residents on air mattresses were moved to wheelchairs, and the residents on oxygen concentrators were all switched to portable oxygen tanks. (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The DON confirmed that she did not do any audits or additional monitoring of residents who were on continuous oxygen during the power outage. Review of the Emergency Preparedness Program for power outages dated September 2018 revealed that interruptions of utility services can create possible health concerns. The facility's emergency generator will normally start automatically when needed. If no life-threatening conditions exist, the situation would be monitored. 2) Review of the medical record for Resident #20, revealed an admission date of 12/14/20. Diagnoses included but were not limited to hemiplegia and hemiparesis following unspecified cerebrovascular disease, major depressive disorder, hypokalemia, hypertension, and vascular dementia. Review of the care plan dated 09/08/22 and ongoing to present revealed Resident #20 was assessed to have communication concerns related to a hearing deficit. The goal for Resident #20 is to have optimal functioning within the limits of hearing impairment as evidenced by the ability to communicate effectively. Interventions for Resident #20 include administering medications as ordered. Review of the Audiology note dated 01/20/25 revealed Resident #20 was seen by the Audiologist and found to be in need of Cerumen (wax) removal and stated for the staff to call Resident #20's physician as soon as possible to obtain orders for wax removal. Review of Resident #20's Physician's Orders revealed an order dated 01/20/25 for Debrox, Otic Solution instill four drops in both ears every night shift for earwax removal for four days four drops a night/irrigate ears after last round of Debrox. Review of Resident #20's MAR dated the month of January 2025 revealed the Debrox was given on 01/20/25, 01/21/25, 01/22/25, and 01/23/25. There was no indication of the irrigation of the ears noted on the MAR. Review of Resident #20's progress notes dated 12/31/24 to 01/31/25 revealed there was no progress note indicating Resident #20's ears had been irrigated after receiving Debrox drops for four nights. Review of the most recent quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a BIMS of 12 which suggests moderate cognitive impairment. During an interview on 09/02/25 at 10:30 A.M. with Resident #20 revealed he had asked multiple people including nurses many times to have his ears cleaned. Resident #20 reported he keeps his television up loud because he can't hear and thinks that if his ears were cleaned, then he could hear. Interview on 09/04/25 at 10:26 A.M. with LPN #304 reported that ears are flushed after the Debrox administration is completed. LPN #304 stated the ears are flushed using warm water which removes the earwax from the ears. LPN #304 revealed the documentation of ear irrigation would be in a progress note and not indicated on the MAR. Interview on 09/04/25 at 11:20 A.M. with the DON revealed the expectation is the nurse will put a progress note in the electronic medical record (EMR) to indicate the ears were irrigated and note how the resident tolerated the procedure. Furthermore, on 09/04/25 at 2:05 P.M. the DON confirmed there was no progress note in the EMR to indicate Resident #20 received irrigation to his ears after the Debrox application. Review of the facility policy titled Documentation in the Medical Record dated 01/08/25 directed documentation should be completed at the time of service or by the end of the shift in which the evaluation, observation, or care service occurred. 3) Review of the medical record for Resident #32 revealed an admission date of 04/21/25 with diagnoses of cerebral infarction, hypertension, convulsions, type 2 diabetes mellitus, malignant neoplasm of the frontal lobe, localization-related idiopathic epilepsy and epileptic syndromes with seizures, generalized anxiety disorder and cognitive communication deficit. Review of the care plan dated 04/22/25 revealed Resident #32 had a seizure/epilepsy disorder related to epilepsy and unspecified convulsions. Interventions included asking the resident about the presence or absence of an aura before a seizure, giving seizure medications as ordered by the physician, and monitoring and documenting side effects and effectiveness. Seizure documentation included location of seizure activity, type of activity (jerks, convulsive movements, trembling), duration, level of consciousness, any incontinence and post-ictal state (sleeping or dazed). Post-seizure treatment included turning the resident on their side with head back and hyperextended to prevent aspiration, keeping the airway open, taking vital signs and performing a neuro check, and monitoring for aphasia, headache, altered LOC (level of consciousness), paralysis, weakness and pupillary changes. Review of the physician's 14 Day as (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	needed orders were active from 08/06/25 through 08/20/25, 08/21/25 through 09/04/25 and 09/05/25 through 09/19/25. Physician orders revealed an order for Lorazepam oral concentrate 2 milligrams (mg)/milliliters (ml), 0.5 ml by mouth every four hours as needed for seizures. Review of the MAR from 08/01/25 through 08/31/25 revealed Resident #32 received 18 administrations of Lorazepam oral concentrate 2 mg/ml, 0.5 ml by mouth as needed for seizures. Administrations were documented on 08/06/25 at 2:40 P.M., 08/07/25 at 8:25 A.M., 08/08/25 at 4:10 P.M., 08/09/25 at 9:00 P.M., 08/10/25 at 4:04 A.M. and 9:06 A.M., 08/11/25 at 4:08 P.M., 08/12/25 at 8:12 A.M., 08/14/25 at 9:28 A.M., 08/15/25 at 11:19 A.M., 08/17/25 at 8:54 A.M., 08/18/25 at 9:00 P.M., 08/20/25 at 7:52 A.M., 08/21/25 at 1:37 P.M. and 10:17 P.M., 08/22/25 at 10:09 P.M., 08/25/25 at 6:43 P.M. and 08/29/25 at 3:10 P.M. Review of progress notes from 08/01/25 through 09/08/25 revealed no documentation of seizure activity for the above administrations of Lorazepam. In addition, review of the record revealed no evidence of seizure monitoring that included seizure location, type of activity (jerks, convulsive movements, trembling), duration, LOC, incontinence and post-ictal state. There was also no confirmation post-seizure interventions were completed, such as turning the resident on their side, keeping the airway open, taking vital signs, performing a neuro check or monitoring for neurological changes. Review of the physician progress note dated 08/24/25 revealed the physician noted that no recent seizure activity had been reported by nursing staff. Review of the MAR from 09/01/25 through 09/08/25 revealed Resident #32 received three administrations of Lorazepam oral concentrate 2 mg/ml, 0.5 ml by mouth as needed for seizures. These were documented on 09/02/25 at 10:57 A.M., 09/04/25 at 10:01 A.M. and 09/05/25 at 2:04 P.M. Interview on 09/08/25 at 11:15 A.M. with the DON confirmed nursing staff are required to document seizure location, type of activity, duration, LOC, incontinence and post-ictal state. Post-seizure care includes turning the resident on their side with head back and hyperextended, keeping the airway open, taking vital signs, performing a neuro check and monitoring for neurological symptoms. Follow-up interview on 09/08/25 at 1:55 P.M. with the DON confirmed Resident #32's medical record did not contain evidence nursing staff followed facility practices or the resident's care plan for seizure management. 4) Record review of Resident #50's medical record revealed medical diagnoses of hypertensive heart disease with heart failure, chronic diastolic heart failure, and cerebral infarction with residual deficits. Resident #50 had a BIMS score of 12 which indicates moderate cognitive impairment. Review of physician orders revealed an order to apply TED (Thrombo-Embolic Deterrent) hose or ace wraps to bilateral lower extremities (BLE) one time a day for edema and circulation, please apply in the AM (morning) and remove HS (night) and remove per schedule. Care plan noted to have intervention of applying TED hose or ace wraps for edema and circulation. Review of Resident #50's Behavior Monitoring and Interventions for 09/03/25 revealed no behaviors observed and no refusals of care noted. Review of Resident #50's progress notes did not indicate Resident #50 refused to wear TED hose or ace wraps or notification to provider of a refusal. Review of Resident #50's TAR notes task for TED hose or ace wrap to be applied to BLE were documented as administered 09/02/25 and 09/03/25. Observation on 09/02/25 at 2:50 P.M. revealed Resident #50's BLE without ace wrap or TED hose. Observation on 09/03/25 at 5:01 P.M. revealed Resident #50's BLE without ace wrap or TED hose. Interview on 09/03/25 at 5:00 P.M. revealed Resident #50 stated she had not been wearing ace wraps or TED hose for months since she does not like them. Interview on 09/03/25 at 5:01 P.M. with Registered Nurse (RN) #198 revealed she documented the order as administered and asked RN #307 to apply TED hose to Resident #50. Interview on 09/03/25 at 5:07 P.M. with RN #307 revealed Resident #50 refused to have TED hose or ace wraps applied on the morning of 09/03/25 and again when asked later in the afternoon and verified documentation in the TAR was not changed. RN #307 verified she was aware of Resident #50's refusals of TED hose and ace wraps and had not notified the medical provider. Review of the Documentation in the Medical Record Policy dated 08/26/16 directed documentation should be accurate, relevant, and complete.		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview and review of the facility policy, the facility failed to identify and treat one (#40) resident's pressure ulcer on her left trochanter (hip) in a timely manner. This resulted in Actual Harm on 08/27/25 when the facility failed to identify and implement a treatment for Resident #40, who was at risk for pressure ulcer development and dependent on staff for activities of daily living, when the resident was identified to have developed an unstageable (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) pressure ulcer to the left trochanter (hip). On 08/28/25, Wound Physician #405 assessed the pressure ulcer to be an unstageable pressure injury. At the time of Wound Physician #405's evaluation, the pressure ulcer measured 3.9 centimeters (cm) length by 3.5 cm width by unable to determine (UTD) cm depth. The wound bed tissue composition was 100 % eschar. The facility failed to identify the area in a timely manner to prevent the ulcer and provide treatment before it was found to be unstageable. Additionally, the facility failed to prevent a second (#16) resident from developing a Stage 2 (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer) pressure ulcer and failed to implement a treatment for a third (#67) resident who was admitted with a pressure ulcer that placed these two (#16 and #67) residents at risk for the potential for more than minimal harm that was not actual harm. This affected three (#40, #16, and #67) of three residents reviewed for pressure ulcers. The facility census was 53. Findings Include: 1) Review of the medical record for Resident #40 revealed an admission date on 06/09/25 from the facility assisted living with severe cognitive deficits. Diagnoses included unspecified dementia, moderate protein calorie malnutrition, type two diabetes, dysphasia and chronic diastolic heart failure. Review of the resident's admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 99 indicating Resident #40 was severely cognitively impaired. The resident required substantial/maximal assistance for bed mobility, including rolling to the left and right side and returning to lying on her back in bed, transfers, ambulation and activities of daily living. The assessment indicated Resident #40 did not have a pressure ulcer. Review of the admission nursing assessment dated [DATE] identified Resident #40 was admitted with no areas of skin impairment. Review Resident #40's Braden Scale for Predicting Pressure Sore Risk dated 06/20/25 revealed a score of 14.0 and on 08/29/25 a score of 15.0 indicating Resident #40 was at a high risk for developing a pressure ulcer. Review of Resident #40's plan of care dated 08/19/25 revealed the resident was at risk for alteration in skin integrity related to diabetes, impaired mobility, incontinence, malnutrition, normal disease progression and nutritional deficit. Interventions included cushion to wheelchair, check placement prior to transfer, encourage and assist as needed to turn and reposition per policy: use assistive devices as needed, encourage to float heels and/or wear heel boots, and provide house liquid protein. Review of Resident #40's physician orders for 08/27/25 identified orders to cleanse wound with normal saline (NS), pat dry with gauze, apply Medi honey, cover with clean dry dressing (CDD), change every day and as needed. On 08/29/25 Wound Physician #405 ordered to cleanse wound with NS, pat dry with gauze, apply calcium alginate to wound bed, apply triad to surrounding skin, and cover with silicone boarder dressing. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Wound Physician #405's Wound Assessment and Plan on 08/28/25 revealed wound location left greater trochanter (rear). Wound type was pressure injury, Unstageable (depth obscured) wound onset 08/27/25. Wound Measurement was 3.9 cm length by 3.5 cm width by UTD depth. The wound was 100% eschar. Treatment included triad to surrounding area, alginate to black central area with foam dressing. Turn and reposition frequently, put pillows to right side to elevate when turned, and low air loss mattress every day and prn. Review of Resident #40's nurses' notes dated 08/27/25 at 4:51 P.M. revealed an area was discovered to the resident's left hip. A wound consult was obtained. Treatment orders were received for alginate and cover with boarder foam. Review of the Incident Report for New Pressure Ulcer dated 08/27/25 at 5:00 P.M. indicated an open area was discovered to Resident #40's left hip. Reviews of Resident #40's July 2025 and August 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) indicated no medications or treatments to Resident #40's left hip until discovery of a pressure ulcer on 08/27/25. Review of the document titled Skin-Total Body Eval-V2 effective date 08/25/25 indicated Resident #40 had no skin abnormalities. Review of Resident #40's Skin and Wound Evaluation dated 08/28/25 indicated a new pressure, unstageable with obscured full-thickness skin and tissue loss due to slough and/or eschar. The area measured 3.9 cm length by 3.0 cm width by UTD depth, wound bed with eschar (100% wound filled). Review of the document titled Skin-Total Body Eval-V2 dated 08/29/25 and 09/01/25 revealed Resident 40 had skin abnormalities. Right trochanter (hip) with red area, left trochanter (hip) with unstageable, and right lower leg (front) red area. Observation on 09/03/25 from 10:15 A.M. to 10:28 A.M. of Resident #40's wound care with Licensed Practical Nurse (LPN) #402 and Certified Nursing Assistant (CNA) #222 revealed a wound on the left side that was discovered on 08/27/25 and was evaluated by Wound Physician #405 on 08/28/25 who categorized it as unstageable. Observation and interview on 09/03/25 at 11:48 A.M. with LPN # 402 confirmed Resident #40 required staff to roll her to her left or right side and then to her back. At the time of the observation, Resident #40 was lying on her left side and LPN #402 put her on her back with wedge pillow on each side. Observation on 09/03/25 at 2:20 P.M. revealed Resident #40 was in her wheelchair without a pressure relieving cushion, sitting in the lounge area. This was verified by CNA #291 at the time of the observation. Interview on 09/04/25 at 12:00 P.M. with CNA #231 who was working with CNA #222 on 08/20/25 when she discovered the pressure ulcer on Resident #40. CNA #231 confirmed CNA #222 reported the pressure area to LPN #304 and Wound Nurse #301. Interview on 09/04/25 at 2:38 P.M. with Wound Nurse #301 confirmed she was not aware of any area of concern on Resident #40's body until it was reported to her on 08/27/25. Interview on 09/04/25 at 4:00 P.M. with CNA #222 and CNA #291 confirmed they reported to LPN #304 and Wound Nurse LPN #301 on 08/20/25 that Resident #40 had a red area that was hot to touch with a blister on her skin, and it was peeling. LPN #304 and Wound Nurse LPN #301 told the CNAs that they already knew about the area. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 09/04/25 at 4:25 P.M. with LPN #402 confirmed that on 08/27/25, Registered Nurse (RN) #322 was taking care of Resident #40 with the night nurse and found a bandage on the resident's left hip. When she removed the bandage, it revealed a pressure ulcer. It was reported to the Director of Nursing (DON) who completed an incident report and an investigation began. It was discovered three CNAs had reported Resident #40 had an area of concern on her left hip to LPN #304 and Wound Nurse LPN # 301 on 08/20/25 and were told by both nurses they knew about the area. Interview on 09/04/25 at 4:39 P.M. with LPN # 304 revealed the nurse denied knowing Resident #40 had any skin issues. The LPN denied treating Resident #40 for skin issues until it was reported to her on 08/27/25. Interview on 09/08/25 at 7:41 A.M. with RN #322 confirmed on 08/27/25 she was doing morning rounds with the night nurse. She was repositioning Resident #40 when she turned the resident's bed and saw an area on her left hip with an awkward bandage that was not dated. She removed the bandage, and it revealed a pressure ulcer that looked like it was unstageable. She reported it to the DON. RN #322 confirmed Wound Nurse #301 and LPN #304 knew about the area and LPN #304 put the bandage on the area because Resident #40 had an order for pad and protect to the resident's right lower extremity. Review of the facility policy titled Skin and Wound Guidelines, dated 03/20/24, revealed a Pressure Injury is localized damage to the skin and underlying soft tissue, usually over a bony prominence or related to a medical or other device. It can be present as intact skin or an open ulcer and may be painful. Injury occurs because of intense and prolonged pressure in combination with shear and is classified by stage. Resident body audits are completed by licensed nurse routinely and documented in the resident's electronic medical record along with the nursing assistant during scheduled bath/showers and if indicated during routine care. The nursing assistant will inform the licensed nurse of any new areas of skin breakdown for evaluation and documentation. Treatment options are based on the type of wound bed and the goal of treatment. Treatments are ordered by the medical practitioner. 2) Review of the medical record for Resident #16 revealed an admission date of 03/23/17. Diagnoses included but were not limited to severe protein-calorie malnutrition, dementia, Alzheimer's, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, hypertension, and major depressive disorder. Review of the care plan initiated on 11/30/22 and ongoing to present revealed Resident #16 had potential impairment to skin integrity. Resident #16's goal was to maintain clean and intact skin by the target date of 08/27/25. Interventions included air mattress, turning and repositioning regularly to relieve pressure points, and skin assessment daily during care. Review of the most recent quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] identified severe cognitive impairment with impaired decision-making skills. The resident was assessed to require one person assist for all activities of daily living (ADL) except as a two person assist for transfers. Resident #16 had very limited bed mobility, only making occasional slight changes in body or extremity but unable to make frequent or significant changes independently. Review of the weekly skin assessment dated [DATE] revealed no skin issues noted. Review of the Braden Scale for Predicting Pressure Sore Risk dated 08/27/25 revealed Resident #16 (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	scored a ten placing the resident at a high risk for pressure sores. Review of a nurse progress note dated 08/27/25 by LPN #304 revealed the nurse on duty observed an open blister to the resident's left gluteus that measured 1.6 cm by 0.9 cm described as blanchable redness noted around open area, new order for skin preparation (prep) every shift was placed. Additionally, a fluid blister that measured 4.2 cm by 3.6 cm was identified to the left heel with a skin prep order in place. The resident's right gluteus area was blanchable redness identified with an order to skin prep every shift. Daughter notified, Nurse Practitioner (NP) aware. Review of physician orders dated 08/27/25 revealed skin prep to red area to left and right gluteus every shift and skin prep to the right heel every shift. Review of the Skin and Wound Evaluation dated 08/28/25 revealed an in-house acquired Stage 2 (partial-thickness skin loss with exposed dermis) pressure ulcer to the left gluteus. The area measured 3.0 cm surface area by 3.0 cm length by 1.4 cm width per nursing. Additionally, the Skin and Wound Evaluation dated 08/28/25 revealed an in-house acquired blister to the right heel that measured 3.7 cm length by 2.9 cm width per nursing. Review of the wound consultant notes dated 08/28/25 noted the wound to the left gluteus as a Stage 2 pressure injury with measurements noted as 4.6 cm length by 2.6 cm width by 0.1 cm depth. The wound to the right heel was noted as a deep tissue pressure injury (DPI) pressure blister measuring 3.7 cm length by 2.9 cm width. Review of the wound consultant notes dated 08/28/25 revealed the following treatment order for the left gluteus: triad to reddened area, honey to open area cover with sacral foam, turn and reposition frequently every day and as needed per the wound physician. Additionally, a treatment order on the wound consultant notes for the right heel consisted of abdominal and kerlix bilateral heel boots every two days and as needed per the wound physician. Review of physician order dated 08/28/25 revealed skin prep to blister to right heel every shift. Additional review of the physician orders dated 08/28/25 revealed no new order for the left gluteus. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed an order dated 08/29/25 which stated turn and reposition every two hours every shift for prevention. Review of the wound consultant orders dated 09/04/25 indicated wound care order site left gluteus: one cleanse with normal saline (NS); two pat dry with gauze; and three apply medi-honey to wound bed cover with sacral foam change every day with night shift for wound care. Review of the physician orders dated 09/04/25 were consistent with the wound consultant orders. Interview on 09/04/25 at 10:34 A.M. with CNA #222 revealed she turns Resident #16 every two hours when she works on unit one and that she observed the wound to Resident #16's left gluteus three weeks prior to 08/27/25. CNA #222 revealed she had told LPN #301 about Resident #16's skin issues. Interview on 09/04/25 at 11:20 A.M. with the DON reported Resident #16 should be turned every two hours. The DON stated there was no place in the electronic medical record for the aides to chart they are turning or repositioning Resident #16 regularly or at all. The DON stated the aides should be checking the Kardex which lists the aide tasks with the care plan. Furthermore, the DON stated there could be an order for turning on the MAR or the TAR but she wasn't sure. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 09/04/25 at 2:18 P.M. with LPN #301, who currently worked as the wound nurse, stated it was possible the aides had told her of the skin issue before 08/27/25 and if it was red and blanchable, then she would not have photographed it. She stated she would not have changed the treatment plan but would only have made sure preventive measures were in place. LPN #301 revealed Resident #16 was to be turned every two hours and there was an order in the MAR for the nurses to sign every shift. LPN #301 revealed there was no place for the aides to sign off they were turning Resident #16 and that the nurses must pay attention to make sure the resident was turned every two hours. Observation on 09/08/25 at 10:08 A.M. with LPN #301 revealed the nurse conducted wound care on Resident #16. Skin prep was applied to the left gluteus and the wound was left open to air. (Physician orders dated 09/04/25 were for cleanse with normal saline [NS]; pat dry with gauze; and apply medi-honey to wound bed cover with sacral foam and change every day). Observation on 09/08/25 at 2:31 P.M. with DON #327 confirmed Resident #16 had no medi-honey wound dressing to the left gluteus per the physician order and the wound was left open to air. Interview on 09/08/25 at 10:33 A.M. with the DON revealed the expectations for the left gluteus wound dressing were to be changed as ordered and the dressing should be replaced if it becomes soiled on any shift or removed for a shower. Interview on 09/08/25 at 10:42 A.M. with LPN #301, in the presence of DON #327, revealed that LPN #301 applied only skin prep to the entire wound area, including the open pressure injury on the left gluteus. Upon reviewing the physician's wound care order, LPN #301 acknowledged that the medi-honey was not applied. DON #327 confirmed this was not consistent with the physician's order and that the medi-honey should have been replaced at that time. Interview on 09/08/25 at 11:22 A.M. with Unit Manager #402 stated it was possible the aides told the nurse before 08/27/25 that Resident#16 had a wound because we are finding this a lot lately. Unit Manager #402 stated the nursing assistants report skin issues to the nurses and that LPN #301 and #304 are the nurses the aides would report skin issues to. Unit Manager #402 revealed LPN #304 should have taken a picture on 08/27/25 when the wound to the gluteus was noted as that is the expectation when a wound is discovered. Unit Manager #402 revealed she rounded with Wound Physician #405 on 08/28/25 and took a photo of Resident #16's gluteus pressure injury. Unit Manger #402 also stated Wound Physician #405 found the wound to the right heel even though LPN #304 said she did a skin assessment on 08/27/25. Unit Manager #402 stated the nurses should be documenting every two hours that Resident #16 has been turned and is not sure why there isn't a place for the aides to document that they are turning Resident #16 every two hours. Interview on 09/08/25 at 2:31 P.M. with the DON confirmed Resident #16 had no medi-honey applied to left gluteus and the wound was open. Review of the facility policy dated 03/20/24 titled Skin and Wound Guidelines indicated body guidelines are completed by the licensed nurse routinely and documented in the resident electronic medical record. Furthermore, the policy states the body audits will be completed by the nursing assistants during scheduled baths/showers and routine daily care and will inform the licensed nurse of any new areas of skin breakdown for evaluation and documentation. Review of the National Pressure Ulcer Advisory Panel (NPUAP) guidelines dated 2014 pages 70-71 at https://cdn.ymaws.com/npiap.com/resource/resmgr/2014_guideline.pdf revealed facilities should (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	educate health professionals on how to undertake a comprehensive skin assessment that included the techniques for identifying blanching response, localized heat, edema, and induration. Further review of the guidelines revealed ongoing assessment of the skin was necessary in order to detect early signs of pressure damage. Visual assessment for erythema (redness of the skin) was the first component of every skin inspection. Skin redness and tissue edema resulting from capillary occlusion was a response to pressure, especially over bony prominences. Staff should conduct a head-to-toe assessment with particular focus on skin overlying bony prominences including the sacrum, ischial tuberosities, greater trochanters and heels and each time the patient was repositioned was an opportunity to conduct a brief skin assessment. 3) Review of Resident #67's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included congestive heart failure, cellulitis of the left lower limb, morbid obesity, atrial fibrillation, diabetes, chronic obstructive pulmonary disease, fibromyalgia, major depression, anxiety, restless leg syndrome and poly-osteoarthritis. Review of the MDS assessment revealed it was in progress and not completed due to the resident being a newer admission. Review of the admission assessment dated [DATE] revealed a Stage 3 (full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole [rolled wound edges] are often present) pressure ulcer to the right buttock measuring 3.39 cm in length, 2.93 cm in width, and 0.2 cm in depth. Review of the physician's orders revealed no ordered treatment to the area at the time of admission. Review of the treatment record revealed no treatment completed to the area. Review of the pressure ulcer risk assessment dated [DATE] identified Resident #67 at risk for pressure ulcers with a score of 19 (score of 15-18 identified to be at risk). Further review revealed Resident #67 was seen by the wound team on 09/04/25 and the wound was assessed. The resident's pressure ulcer was identified as a Stage 3 pressure ulcer measuring 3.3 cm in length by 2.7 cm in width by 0.1 cm in depth. A physician's order was written to cleanse the wound with normal saline or sterile water, apply calcium alginate to the wound bed and cover with a dry dressing every day and as needed. On 09/04/25 at 2:04 P.M., interview with the DON revealed no treatment was started for the pressure ulcer until 09/04/25 after the wound team assessed the area.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 policy review the facility failed to safely store and prepare food in the kitchen. This had the potential to affect all 53 of 53 residents who receive meals from the kitchen. The census was 53. Findings Include: 1. Observation of the kitchen on 09/02/25 at 8:43 A.M. revealed the internal part of the ice machine had a red substance that was removed when wiped with a glove. Interview with the Dietary Manager on 09/02/25 at 8:43 A.M. verified there was a red substance inside of the ice machine. 2. Observation of the dry storage in the kitchen on 09/02/25 at 8:52 A.M. revealed greasy and dirty shelving above open boxes of plastic utensils. Interview on 09/02/25 at 8:52 A.M. with the Dietary Manager verified the shelving was dirty above the open boxes of plastic utensils. Review of the facility's Food Storage policy dated 04/01/22 verified all shelving in dry storage should be cleanable. 3. Observation of the dry storage in the kitchen on 09/02/25 at 8:53 A.M. revealed two fifty-ounce tomato soup cans with the top lids smashed in. Observation of the dry storage in the kitchen on 09/02/25 at 8:53 A.M. revealed four 13.5 oz cans of tomato sauce with dented lids. Interview with the Dietary Manager on 09/02/25 at 8:55 A.M. verified these cans should not be out for use. Review of the facility's Food Storage policy dated 04/01/22 verified dented cans must be removed from circulation, identified as damaged and reported to the vendor for credit. 4. Observation in the kitchen during dinner service on 09/02/25 at 5:01 P.M. revealed Dietary Aide #217 use gloved left hand to turn on faucet knob to rinse knife, then used gloved left hand to cut onion without changing gloves in between. Interview on 09/02/25 at 5:02 P.M. with Dietary Aide #217 verified she did not change gloves or perform hand hygiene after touching the faucet knob and before cutting the onion. Review of the facility's Hand Washing policy, dated 01/14/2025, verified food employees shall clean their hands before engaging in food preparation. During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks.		

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. Based on interviews and policy and procedure review the facility failed to ensure a Resident Trust authorization Forms were not witnessed by facility staff. This affected six residents (#10, #38, #45, #52, #75 and #76) reviewed for personal care need accounts. The census was 53. Findings Include: 1. Review of Resident #38's Resident Fund Management Service Authorization and Agreement to Handle Resident Funds revealed Business Office Manager # 321 signed as a witness to allow the facility to handle Resident #38 personal care needs account on 07/07/25. 2. Review of Resident #10's Resident Fund Management Service Authorization and Agreement to Handle Resident Funds revealed Business Office Manager # 321 signed as a witness to allow the facility to handle Resident #10 personal care needs account on 02/12/24. 3. Review of Resident #52's Resident Fund Management Service Authorization and Agreement to Handle Resident Funds revealed Business Office Manager # 321 signed as a witness to allow the facility to handle Resident #52 personal care needs account dated for 03/31/25. 4. Review of Resident #45's Resident Fund Management Service Authorization and Agreement to Handle Resident Funds revealed Business Office Manager # 321 signed as a witness to allow the facility to handle Resident #45 personal care needs account on 02/12/24. 5. Review of Resident #75's Resident Fund Management Service Authorization and Agreement to Handle Resident Funds revealed Business Office Manager # 321 signed as a witness to allow the facility to handle Resident #75 personal care needs account. The authorization form was not dated. 6. Review of Resident #76's Resident Fund Management Service Authorization and Agreement to Handle Resident Funds revealed Business Office Manager # 321 signed as a witness to allow the facility to handle Resident #76 personal care needs account on 12/26/24. Interview on 09/04/25 with the Administrator at 9:15 A.M. confirmed the Resident Fund Management Service Authorization and Agreement to Handle Resident Funds Forms for Residents #10, #38, #45, #52, #75 and #76 were witnessed by the Business Office Manager. Review of facility policy titled Resident Trust Fun, dated 07/05/24, revealed when a facility is serving as a Representative Payee, it shall fulfill its duties in accordance with the federal rules.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to identify, treat and monitor weight loss. This affected five residents (#42, #23, #29, #38 and #44) out of seven residents reviewed for weight changes. The facility census was 53. Findings Include: 1. Review of Resident #42's medical record revealed that she was admitted on [DATE]. Diagnoses for Resident #42 included Type II diabetes mellitus with diabetic chronic kidney disease, hypertensive heart and chronic kidney disease, and chronic respiratory failure with hypoxia. Review of Resident #42's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15. Resident #42 functional ability assessment for eating as independent but was dependent for chair to bed transfers. Resident #42 was assessed weighing 222 pounds (lbs) having no significant weight change and on a therapeutic diet. Review of Resident #42's care plan revealed Resident #42 was on therapeutic diet to aide in fluid control related to CHF and blood glucose control, weight stable without wo significant change. Potential for decreased kidney function related to diagnosis of DM with possible influence on hydration. Intervention includes review weights and notify physician and responsible party of significant weight change. Review of Resident #42's weight revealed that on 07/08/25 Resident #42 weighted 220.5 lbs using the hoyer scale. On 07/24/25, the weight noted in the medical record was 186.9 lbs. Review of Resident #42's progress note dated 07/30/25 Weight loss noted, Potential for weight discrepancy related to different scales used. Potential for weight change/fluctuation related to diuretic use. Interview with Clinical Dietitian #284 on 09/03/25 at 2:22 P.M. confirmed that she had been made aware of the possibility of scale issues or weighing issues by nursing care team members. Interview with the Director of Nursing (DON) on 09/03/25 at 2:45 P.M. revealed that she was unaware what the re-weigh policy was for residents who had a weight discrepancy. The DON revealed that she would expect for the resident to be reweighed within 24 hours of a large weight discrepancy. Interview with Corporate Dietitian #450 on 09/04/25 at 10:06 A.M. revealed that she was made aware of inconsistencies with the facility scales on 08/28/25. Interview with Regional Nurse #415 on 09/04/25 at 11:56 A.M. revealed that arrangements have since been made to calibrate the facility's scales. 2. Review of the medical record for Resident #44 revealed an admission date of 08/14/24 with diagnoses of pulmonary heart disease, morbid obesity, heart failure, chronic obstructive pulmonary disease, type 2 diabetes mellitus, chronic kidney disease, hemiplegia and hemiparesis, repeated falls and major depressive disorder. Review of the nutritional evaluation dated 08/16/25 revealed Resident #44 is at risk of malnutrition related to chronic disease with a noted need for an altered diet and obesity status. Interventions include monitoring weights. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician order dated 08/16/24 revealed a diabetic/consistent carb/carb-controlled diet. Review of the care plan dated 08/16/24 revealed Resident #44 is at risk for malnutrition related to chronic disease with a noted need for an altered diet and obesity status. Interventions include monitoring, recording and reporting to the physician any significant weight loss such as more than five percent in one month, seven and a half percent in three months or ten percent in six months. Staff are to obtain weights per facility protocol, review weights and notify the physician and responsible party of significant weight changes. Review of the weight summary dated 06/04/25 revealed Resident #44 weighed 268.4 pounds. On 07/01/25, the resident weighed 234 pounds, a -12.82% loss. Additional weights were recorded on 08/02/25 at 232.9 pounds and on 08/08/25 at 236.2 pounds. Review of dietary progress notes dated 07/01/25 through 09/08/25 revealed one note for Resident #44 dated 08/12/25. The resident was identified with a weight loss, though weights were noted to have stabilized. The note mentioned a potential discrepancy due to scale differences. IDT was aware. Per nursing staff, the resident eats well. The resident denied nausea or loose stools. No recommendations were made and no additional notes were documented. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment completed 08/05/25 revealed Resident #44 is cognitively intact, requires setup or clean-up assistance with eating, has experienced a weight loss of 5% or more in the last month or 10% or more in the last six months and is not on a physician-prescribed weight-loss regimen. Interview on 09/03/25 at 2:31 P.M. with the Clinical Dietician #284 revealed Resident #44 had a significant weight change, with a documented loss on 07/01/25. The dietician confirmed this weight loss was not addressed until 08/12/25. They stated it was unclear whether the loss was actual or due to a scale discrepancy. A resident interview, staff interview and record review were completed, which did not provide evidence of true weight loss. No additional follow-up was conducted pertaining to the -12.82% weight loss in one month. Interview on 09/03/25 at 2:45 P.M. with the Director of Nursing revealed uncertainty regarding any issues with the facility's scales or their calibration dates. The director stated no education had been provided to nursing staff on proper weighing procedures. When asked about protocol, the director indicated a reweigh would typically be expected within 24 hours in the event of a large weight discrepancy. The director also confirmed scale-related concerns had not been discussed during IDT meetings. Interview with Corporate Dietitian #450 on 09/04/25 at 10:06 A.M. revealed that she was made aware of inconsistencies with the facility scales on 08/28/25. Interview with Regional Nurse #415 on 09/04/25 at 11:56 A.M. revealed that arrangements have since been made to calibrate the facility's scales. 3. Review of the medical record for Resident #38 revealed an admission date of 06/03/25 with diagnoses including type 2 diabetes mellitus, chronic kidney disease, major depressive disorder, irritable bowel syndrome with constipation, and gastroesophageal reflux disease without esophagitis. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan dated 06/04/25 identified the resident as being at nutritional risk. Interventions included administering medications as ordered, alerting the dietician if consumption was poor, and encouraging socialized dining. A nutritional evaluation dated 06/10/25 confirmed that Resident #38 was at risk of malnutrition due to chronic disease and body mass index status. Recommendations included a special diet and encouragement of food and fluid intake. Review of the Quarterly Minimum Data Set (MDS) 3.0 assessment completed on 08/16/25 revealed that Resident #38 is cognitively intact, independent with eating, and had not experienced weight loss or gain in the past month or six months. However, a review of the weight summary showed that on 09/01/25, the resident weighed 158 pounds, representing a 9.09% loss from her weight of 173.8 pounds recorded on 07/03/25. Review of the progress note revealed that the dietician was not notified of the significant weight change documented on 09/01/25. Interview conducted on 09/03/25 at 2:31 p.m. with the clinical dietician #284 confirmed that Resident #38 had experienced a significant weight change. The dietician stated she was unaware of the change and could not confirm whether it was due to a scale issue or actual weight loss. She acknowledged that the weight loss had not yet been addressed. Interview on 09/03/25 at 2:45 P.M. with the Director of Nursing revealed uncertainty regarding any issues with the facility's scales or their calibration dates. The director stated no education had been provided to nursing staff on proper weighing procedures. When asked about protocol, the director indicated a reweigh would typically be expected within 24 hours in the event of a large weight discrepancy. The director also confirmed scale-related concerns had not been discussed during IDT meetings. Interview with Corporate Dietitian #450 on 09/04/25 at 10:06 A.M. revealed that she was made aware of inconsistencies with the facility scales on 08/28/25. Interview with Regional Nurse #415 on 09/04/25 at 11:56 A.M. revealed that arrangements have since been made to calibrate the facility's scales. 4. Review of Resident #23's medical record revealed that she was admitted to the facility on [DATE]. Diagnoses for Resident #23 included focal traumatic brain injury, chronic systolic heart failure, and pulmonary hypertension. Review of Resident #23's most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed that she had a Brief Interview for Mental Status (BIMS) score of 12, indicative of intact cognition. Resident #23 was assessed as requiring substantial/ maximal assistance for sitting to standing and transfers. Resident #23 was assessed as weighing 280 pounds (lbs) and having no weight changes of significance and being on a therapeutic diet. Review of Resident #23's nutrition care plan dated 06/28/25 revealed that Resident #23 was on a therapeutic diet and had potential for significant weight loss. Her goal was to have no significant weight changes. Interventions listed included to monitor weights, and to have the dietitian evaluate and make diet changes as needed. Review of Resident #23's weights revealed that on 08/06/25, Resident #23 weighed 280 lbs. On (continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366142	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/10/2025
NAME OF PROVIDER OR SUPPLIER Mill Run Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3399 Mill Run Drive Hilliard, OH 43026	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	08/27/25, the documented weight in the medical record was 253.4 lbs., indicative of a significant weight loss of 9.5% in less than 30 days, or 26.6 lbs. Review of Resident #23's medical record revealed that the dietitian had not yet addressed the significant weight changes as of 09/03/25. An interview with Clinical Dietitian #284 on 09/03/25 at 2:22 P.M. confirmed that she had not yet investigated the weight loss of Resident #23, and that she had been made aware of the possibility of scale issues or weighing issues by nursing care team members. An interview with the Director of Nursing on 09/03/25 at 2:45 P.M. revealed that she was unaware what the re-weigh policy was for residents who had a weight discrepancy in the medical record. The Director of Nursing revealed that she had not done any educations about proper weighing procedures with the nursing staff nor investigated calibrating the scales in the facility. The Director of Nursing revealed that she would expect for the nursing team to reweigh residents within 24 hours of a large weight discrepancy. An interview with Corporate Dietitian #450 on 09/04/25 at 10:06 A.M. revealed that she was made aware of inconsistencies with the facility scales on 08/28/25. An interview with Regional Nurse #415 on 09/04/25 at 11:56 A.M. revealed that arrangements have since been made to calibrate the facility's scales. 5. Review of Resident #29's medical record revealed that she was admitted to the facility on [DATE]. Diagnoses for Resident #29 included focal traumatic brain injury, moderate protein calorie malnutrition, and systemic lupus. Review of Resident #29's most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed that Resident #29 had a Brief Interview for Mental Status (BIMS) score of 15, indicative of intact cognition. She was assessed as requiring substantial/ maximal assistance for personal hygiene and was dependent for mobility. Resident #29 was assessed as weighing 172 pounds (lbs.) and having no weight changes of significance in the past one month and six months. Review of Resident #29's weights in the medical record revealed that she weighed 172 lbs. on 08/06/25 and 08/07/25, 135.92 lbs. on 08/27/25- which would be a significant weight loss of 21%, or 36 lbs., in less than 30 days, 132.5 lbs. on 08/28/25, 133.4 lbs. on 08/29/25, 133.2 lbs. on 09/01/25, and 125 lbs. on 09/04/25. An interview with Clinical Dietitian #284 on 09/03/25 at 2:22 P.M. confirmed that she had not yet investigated the weight loss of Resident #29, and that she had been made aware of the possibility of scale issues or weighing issues by nursing care team members. An interview with the Director of Nursing on 09/03/25 at 2:45 P.M. revealed that she had not done any educations about proper weighing procedures with the nursing staff nor investigated calibrating the scales in the facility. An interview with Corporate Dietitian #450 on 09/04/25 at 10:06 A.M. revealed that she was made aware of inconsistencies with the facility scales on 08/28/25. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Regional Nurse #415 on 09/04/25 at 11:56 A.M. revealed that arrangements have since been made to calibrate the facility's scales. Review of the facility policy approved on 05/29/25 titled, Weight Management Protocols, revealed that routine weight monitoring is a preventative care measure used in assessing a resident's risk of malnutrition, functional decline, disease severity, or other associated adverse outcomes. The clinical nutrition staff will review all monthly and weekly weight records on a routine basis and further evaluate for weight change meeting or exceeding 5% in one month. If significant weight loss is noted, the interdisciplinary team should review for possible causes of changed intake, changed caloric need, change in medication, or changed volume status. Progress note documentation will be completed by the clinical nutrition staff on all residents with newly identified or ongoing significant weight change to determine cause or conditions that put the resident at nutritional risk.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review, and interview the facility failed to implement infection control practices. This affected six residents (#38, #6, #9, #40, #23, and #77) of 53 residents residing in the facility. Findings Include: 1. Review of Resident #38's medical record revealed diagnoses of Type II diabetes mellitus with chronic kidney disease and nonrheumatic aortic valve stenosis. Brief Interview for Mental Status (BIMS) score of 14. Review of Resident #6's medical record revealed diagnoses of Type II diabetes mellitus with diabetic neuropathy and dysphagia following cerebral infarction. Brief interview for Mental Status (BIMS) score of 10. Review of Resident #9's medical record revealed diagnoses of Type II diabetes with diabetic chronic kidney disease and chronic systolic heart failure. Brief Interview for Mental Status (BIMS) score of 07. Observation on 09/04/25 at 8:20 A.M. revealed Certified Nurse Aide (CNA) #291 passing meal trays in 100 hall. Observation on 09/04/25 at 8:27 A.M. revealed CNA #291 cleared Resident #38's table for breakfast by removing Resident #38's water bottle and placing the tray on the table. Observation on 09/04/25 at 8:28 A.M. CNA #291 was observed leaving Resident #38's room and did not perform hand hygiene after leaving Resident #38's room and before reaching into warmer to get a tray for Resident #6 and Resident #9. Observation on 09/04/25 at 8:29 A.M. revealed CNA #291 removed breakfast tray from warmer for Resident #6 assisted Resident #6 with tray set up. Observation on 09/04/25 at 8:30 A.M. revealed CNA #291 left Resident #6's bedside and did not perform hand hygiene after assisting with tray set up upon leaving the room. Observation on 09/04/25 at 8:30 A.M. revealed CNA #291 removed breakfast tray from warmer for Resident #9 and assisted with tray set up and moving table. Observation on 09/04/25 at 8:32 A.M., revealed CNA #291 left Resident #9's room and did not perform hand hygiene after assisting with tray set up and moving the table. Interview on 09/04/25 at 8:35 A.M. with CNA #291 verified they did not do hand hygiene during observed breakfast tray pass. Review of the facility's Hand Hygiene Policy dated 04/14/23 verified situations in which using soap and water or alcohol based hand rub can be used when between direct contact with residents and after handling contaminated objects. Review of the facility's Infection Control- Standard and Transmission- Based Precautions dated 03/04/24 verified standard precautions include hand hygiene. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the medical record for Resident #40 revealed an admission date of 06/09/25 with diagnoses including dementia, Type II diabetes mellitus, moderate protein-calorie malnutrition, anxiety, and muscle weakness. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment completed 08/25/25 revealed Resident #40 exhibited inattention and disorganized thinking, had no open skin areas, and had skin prevention treatments in place including pressure-reducing devices to chair and bed, nutrition or hydration interventions, and application of ointments and medications. Review of the care plan dated 08/28/25 revealed the resident required Enhanced Barrier Precautions (EBP) related to a wound. Interventions included implementing EBP and educating the resident and family on EBP policies. Review of the physician order dated 08/29/25 revealed an order for Enhanced Barrier Precautions related to a wound. Review of the skin total body evaluation dated 08/29/25 revealed impaired skin integrity including a red area on the right trochanter (hip), an unstageable wound on the left trochanter (hip), and a red area on the right lower leg. A wound care consult was ordered. Review of the skin and wound evaluation dated 08/28/25 revealed an in-house acquired unstageable pressure injury on the left trochanter (hip) due to slough and/or eschar, measuring 9.3 cm2 (3.9 cm x 3.5 cm) with 100% eschar. Observation of wound care on 09/03/25 from 10:15 A.M. to 10:28 A.M. with Unit Manager #402 and CNA #222 revealed the wound on the left side was described as a newer wound currently being treated by the wound physician. Current skin interventions included wedges, heel floating with pillows, air mattress, and turning every two hours. Staff confirmed the resident frequently gets out of bed and tends to posture to both the left and right sides. During the observation, the resident received wound care to the left hip including cleansing with normal saline, application of calcium alginate to the wound bed, Triad to the surrounding area, and a bordered foam dressing. Supplies were confirmed and hand hygiene was performed before donning gloves. EBP signage was posted outside the resident's room, indicating staff should wear gown and gloves during personal care. However, throughout the entire wound care procedure, neither Unit Manager #402 nor CNA #222 donned a gown. Interview on 09/03/25 at 10:28 A.M. with Unit Manager #402 confirmed gowns should have been worn during the wound care procedure and acknowledged that EBP signage was posted outside the resident's room. Review of the facility's Enhanced Barrier Precaution policy dated 09/03/25 revealed that EBP includes the use of gown and gloves during high-contact activities for residents with indwelling medical devices or open wounds. High-contact activities include dressing, bathing/showering, transferring, providing hygiene, changing linens, and wound care. 3. On 09/03/25 at 8:11 A.M. observation of Registered Nurse (RN) #287 when obtaining the finger stick blood sugar (FSBS), RN #287 went into the resident's room and failed to provide a barrier to be placed on the overbed table to place the glucometer on and failed to clean it prior to use, then after obtaining Resident #77's FSBS took the glucometer to the medication cart. RN #287 wiped with a microdot bleach wipe for five seconds and then laid the glucometer on the medication cart with no (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	barrier to dry. Review of the directions for the microdot bleach wipe revealed to apply the towelette and wipe the surface. Contact time 30 seconds for most bacteria and viruses, keep surfaces visibly wet during contact time. Review of the Glucometer Testing Review dated 01/2023 revealed nurses cleanses the glucometer with germicidal wipes and glucometer remains visibly wet for three minutes. The nurse establishes a clean barrier. This was verified during interview with RN #287 on 09/03/25 at 8:23 A.M. 4. Review of Resident #23's medical record revealed that she was admitted to the facility on [DATE]. Diagnoses for Resident #23 included focal traumatic brain injury, chronic systolic heart failure, and pulmonary hypertension. Review of Resident #23's most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed that she had a Brief Interview for Mental Status (BIMS) score of 12, indicative of intact cognition. Resident #23 was assessed as requiring substantial/ maximal assistance for sitting to standing and transfers. Review of Resident #23's physician orders revealed that she was to be under contact precautions for conjunctivitis, and that all services to be provided in private room starting on 08/29/25 and ended on 09/02/25 at 1:22 P.M. Review of Resident #23's Treatment Administration Record (TAR) revealed that she was on contact precautions 08/29/25 through 09/02/25. Observation of meal service for Resident #23 on 09/02/25 at 12:54 P.M. revealed that Licensed Social Worker (LSW) #212 entered Resident #23's room without wearing any personal protective equipment and set up the lunch meal tray for Resident #23. LSW #212 was observed to be within one foot of Resident #23 and was observed touching her bedside table as he set up her meal items in preparation for her to eat her lunch. An interview with LSW #212 on 09/02/25 at 1:09 P.M. confirmed that he did enter Resident #23's room without wearing any personal protective equipment and was setting up her meal tray in close proximity to Resident #23. An interview with the Director of Nursing on 09/02/25 at 1:12 P.M. revealed that her expectations for staff entering a room for a resident under contact precautions would be for the staff member to wear gloves and a gown upon entering their room. Further interview revealed that only one resident in the facility (Resident #9) was under contact precautions. Review of a facility policy issued on 04/01/20 and revised on 03/04/24 titled, Infection Control-Standard and Transmission-Based Precautions, revealed that contact precautions include personal protective equipment: gloves are to be applied before entering and removed before leaving the resident's room and perform hand hygiene, and gowns are to be applied upon entering and before leaving the resident's room and perform hand hygiene.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview and review of the facility policy the facility failed to ensure privacy was maintained while providing personal care for residents. This affected two residents (#16, #67) of 31 sampled residents. The census was 53. Findings Include: 1. Review of Resident #67's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included CHF, cellulitis of the left lower limb, morbid obesity, atrial fib, diabetes, COPD, fibromyalgia, major depression, anxiety, restless leg syndrome and poly- osteoarthritis. Review of the minimum data set (MDS) assessment revealed it was in progress and not completed due to Resident #67 being a newer admission. On 09/04/25 at 10:59 A.M. observation of perineal care for Resident #67 revealed Certified Nurses Aide (CNA) #342 when completing perineal care left the blinds open while the resident's body was exposed. On 09/04/25 at 11:12 A.M. interview with CNA #342 verified she had not closed the blinds to provide privacy for Resident #67 prior to completing the perineal care. 2. Review of the medical record for Resident #16, revealed an admission date of 03/23/17. Diagnoses included but were not limited to severe protein-calorie malnutrition, dementia, Alzheimer's, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, hypertension, major depressive disorder. Review of the care plan dated 11/30/22 revealed Resident #16 has an activity of daily living (ADL) self-care performance related to Alzheimer's, dementia, impaired vision, cognitive and communication deficits, and decreased mobility. The intervention stated Resident #16 required a one-person assist with showers which are to be given twice weekly and as needed. Review of the most recent quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] identified the resident was severely impaired with decision making skills. The resident was assessed to require one person assist for all activities of daily living (ADL) except the resident required a two person assist for transfers. Observation on 09/08/25 at 9:46 A.M. revealed Hospice Aide #406 wheeled Resident #16 down the unit one hallway in a Broda shower chair. Resident #16 was naked with only a sheet covering her with her back exposed for the public to view. Resident #16's hair was wet, and the resident was saying Help me please, my back is hurting as she was being wheeled down the unit one hallway. Interview on 09/08/25 at 9:53 A.M with Facility Aide #289 confirmed Resident #16 was in shower chair naked with only a sheet covering her when she arrived in the room. Interview on 09/08/25 at 10:11 A.M. with the Director of Nursing (DON) #327 confirmed Resident #16 was brought out of the shower room naked with only a sheet wrapped around her as she was wheeled down the unit one hallway. Review of the facility policy dated 09/21/23 labeled as Dignity stated residents will be treated with dignity and respect at all times.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interviews, medical record reviews, and policy and procedure review, the facility failed to ensure residents receiving skilled services were notified within 48 hours of their skilled services ending. This affected two residents (#71 and #72) of three residents reviewed for Beneficiary Notices. The census was 53. Findings Include: Review of Resident #71's SNF Beneficiary Protection Notification Review revealed her Medicare Part A Skilled Services started on 07/04/25 and her last covered day of Part A Services was on 07/24/25. Resident #71 signed her notification of Medicare Non-Coverage letter on 07/23/25. Review of Resident #72's SNF Beneficiary Protection Notification Review revealed her Medicare Part A Skilled Services started on 06/17/25 and his last covered day of Part A Services was on 07/29/25. Resident #72 signed his notification of Medicare Non-Coverage letter on 07/28/25. Interview on 09/04/25 at 7:18 A.M. with the Administrator confirmed Resident #71 and Resident #72 did not receive notification of skilled services ending within 48 hours. Review of facility policy titled Advanced Beneficiary Notification (ABN), dated 03/01/25, revealed the facility is to provide timely written notice to traditional Medicare beneficiaries when it is determined that Medicare will no longer provide coverage for skilled services, The Advanced Beneficiary Notification (ABN) is utilized to convey the cost of services and potential financial liability.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure Minimum Data Set (MDS) 3.0 assessments were coded correctly. This affected two residents (#62, #5) of three residents reviewed for minimum data set transmission. The facility census was 53. Findings Include:1. Review of Resident #5's medical record revealed an admission date of [DATE] and discharge date of [DATE]. Diagnoses included malignant neoplasm of the esophagus and type II diabetes mellitus with diabetic polyneuropathy. Review of Resident #5's progress notes revealed a note on [DATE] that stated Resident #5's belongings were collected by son. Resident #5 was to be admitted to [NAME] for chemotherapy treatment. Review of the MDS dated [DATE] revealed the MDS was coded as discharge assessment- return anticipated. Interview on [DATE] at 3:35 P.M. with MDS Nurse #400 verified the facility was not anticipating Resident #5 coming back to the facility and would modify the MDS to reflect this. 2. Review of the medical record for Resident #62 revealed an admission date of [DATE] and a discharge date of [DATE], with diagnoses including surgical aftercare following digestive system surgery, hypertension, post-polio syndrome, poly-osteoarthritis and generalized anxiety disorder. Review of the progress note dated [DATE] at 7:01 A.M. revealed Resident #62 experienced a change in condition that warranted transfer to the hospital. The resident was observed with altered respirations, felt hot to the touch, had fixed pupils with a glazed appearance and was unresponsive but staring. Review of the Minimum Data Set (MDS) 3.0 assessment completed on [DATE] identified Resident #62's assessment was coded as death in the facility. Review of the hospital record dated [DATE] revealed Resident #62 was admitted with diagnoses of acute respiratory failure with hypoxia and hypercapnia, encephalopathy, sepsis, and hypoglycemia. A discussion with the family confirmed the resident's wish was to pass naturally. A decision was made to transition to comfort care, proceed with compassionate extubation, and the time of death was recorded on [DATE] at 12:25 P.M. Interview conducted on [DATE] at 10:28 A.M. with MDS Coordinator #400 confirmed Resident #62's MDS assessment completed [DATE] was coded as a death in the facility because the resident passed shortly after arriving at the emergency room. The coordinator stated that if a resident dies within 24 hours of hospital transfer, the facility is responsible for coding the death on the MDS as death in facility. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User Manual, Version 1.20.1, dated [DATE], confirmed that death in facility refers to a resident who dies either in the facility or while on a leave of absence (LOA).		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to develop and implement a plan of care upon the resident's admission in regard to a pressure ulcer that was present on admission. This affected one resident (#67) of three residents reviewed for pressure ulcers. The census was 53. Findings Include: Review of Resident #67's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included CHF, cellulitis of the left lower limb, morbid obesity, atrial fib, diabetes, COPD, fibromyalgia, major depression, anxiety, restless leg syndrome and poly-osteoarthritis. Review of the minimum data set (MDS) assessment revealed it was in progress and not completed due to Resident #67 being a newer admission to the facility. Further review of the plan of care revealed no evidence of a basic comprehensive plan of care for the pressure ulcer that was present upon the resident's admission to the facility. This was verified during interview with the Director of Nursing on 09/04/25 at 2:04 P.M.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record reviews, staff interviews and review of facility policy, the facility failed to have quarterly care conferences as expected for two residents (#9, #18). Also, the facility failed to have a nutrition care plan in place for one resident (#29). This affected three residents (#9, #18, #29) out of three residents reviewed for care planning. The facility census was 53 residents. Findings Include: Findings include: 1. Review of Resident #9's medical record revealed that the resident was admitted to the facility on [DATE] and had diagnoses that included cerebral infarction, dementia and schizoaffective disorder. Review of Resident #9's most recent comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed that she had a Brief Interview for Mental Status (BIMS) of 07, indicative of severe cognitive impairment. Resident #9 was assessed as requiring partial to moderate assistance with toileting hygiene, showering assistance and mobility. Review of Resident #9's care plan dated 05/12/23 revealed that Resident #9 may exhibit symptoms of a psychosocial well-being problem related to her diagnoses of dementia and schizoaffective disorder. One of Resident #9's care plan goals was listed as demonstrating adjustment to nursing home placement. An intervention dated 05/12/2023 was to provide opportunities for the resident and family to participate in care. Review of Resident #9's progress notes and health care conference assessments revealed that she had care conferences on 05/25/23, 09/11/24, and 04/18/25. There were no additional care conferences listed in the medical record. An interview with Social Services Coordinator #220 on 09/08/25 at 11:34 A.M. revealed that care conferences should be documented quarterly in either the health care conference assessment or the progress notes in the medical record. An interview with the Director of Nursing on 09/08/25 at 1:55 P.M. confirmed that there were no other care conference meetings held for Resident #9 other than on 05/25/23, 09/11/24, and 04/18/25. 2. Review of Resident #18's medical record revealed that she was admitted to the facility on [DATE] and had diagnoses that included chronic respiratory failure, depression, chronic kidney disease and chronic congestive heart failure. Review of Resident #18's most recent comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed that she had a Brief Interview for Mental Status (BIMS) of 12, indicative of intact cognitive status. Resident #18 was assessed for being dependent for showering/ bathing, dressing, and for mobility. Review of Resident #18's plan of care dated 06/05/24 revealed that Resident #18 may exhibit symptoms of a psychosocial well-being problem related to her diagnosis of depression. A goal listed on the care plan was that Resident #18 would demonstrate adjustment to the nursing home placement. A listed intervention dated 06/05/24 was that the facility would provide opportunities for the resident and family to participate in care. Review of Resident #18's progress notes and health care conference assessments revealed that she had care conferences on 09/24/24 and 05/29/25, but no other care conference meetings. An interview with Social Services Coordinator #220 on 09/08/25 at 11:34 A.M. revealed that care conferences should be documented quarterly in either the health care conference assessment or the progress notes in the medical record. An interview with the Director of Nursing on 09/08/25 at 2:52 P.M. confirmed that Resident #18 had care conferences on 09/24/24 and 05/29/25, and that those two care conferences were the only two care conferences that had been held for Resident #18. 3. Review of Resident #29's medical record revealed that she was admitted to the facility on [DATE]. Diagnoses for Resident #29 included focal traumatic brain injury, moderate protein calorie malnutrition, and systemic lupus. Review of Resident #29's most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed that Resident #29 had a Brief Interview for Mental Status (BIMS) score of 15, indicative of intact cognition. She was assessed as requiring substantial/ maximal assistance for personal hygiene and was dependent for mobility. Review of Resident #29's nutrition care plan revealed that there was no nutrition care plan available. An interview with Corporate Dietitian #450 on 09/04/25 at 4:27 P.M. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Mill Run Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3399 Mill Run Drive Hilliard, OH 43026	
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed that there was no nutrition care plan in place for Resident #29. Review of the facility policy dated 08/31/23 titled, Care plan Review Process, revealed that the interdisciplinary team is responsible for creating, reviewing and updating a care plan on admission and at least quarterly. The focus of the care plan to support the resident in making their own choices and having control over their own daily life.		

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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 observation, interview and record review the facility failed to ensure residents who were dependent on staff for activities of daily living (ADLs) received timely and adequate staff assistance with showers and personal hygiene. This affected one resident (#44) of two residents reviewed for ADL care. The facility census was 53. Findings Include: Review of the medical record for Resident #44 revealed an admission date of 08/14/24 with diagnoses of pulmonary heart disease, morbid obesity, heart failure, chronic obstructive pulmonary disease, type 2 diabetes mellitus, chronic kidney disease, hemiplegia and hemiparesis, repeated falls and major depressive disorder. Review of care plan dated 08/16/24 revealed Resident #44 had an ADL self care deficit as evidenced by needed assist of 1-2 persons, cerebral vascular accident with left hemiplegia, incontinence, edema of bilateral lower extremities and recent and frequent falls. Interventions include assist to bathe/shower as needed and assist with daily hygiene, grooming, dressing, oral care and eating. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment completed 08/05/25 revealed Resident #44 was cognitively intact and dependent on staff for showering and bathing. Review of the ADL - Bathing task from 08/01/25 through 09/05/25 revealed Resident #44 received a total of three bed baths/showers in one month, occurring on 08/25/25, 08/29/25 and 09/02/25. Review of progress notes dated 08/01/25 through 09/05/25 revealed Resident #44 had not been out of the facility on leave of absences or hospitalizations. Interview on 08/02/25 at 11:20 A.M. revealed Resident #44 was observed with long facial hair and complained about greasy hair and concerns regarding the lack of showers or baths. Interview on 08/04/25 at 2:32 P.M. with the Director of Nursing confirmed the facility does not use paper bath sheets to document bathing. Staff are expected to use the bathing task only. The Director confirmed Resident #44's medical record did not show evidence of more than three baths were completed in a one-month period. She acknowledged this is not consistent with facility practice and residents are to receive at least 2-3 baths per week or as preferred. Review of shower policy dated 01/07/25 revealed residents will be provided with showers as per request and per facility schedule based upon resident preference and safety.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, observation, staff interview, and facility policy review, the facility failed to maintain infection control with the storage of respiratory equipment and the administration of respiratory medication. This affected two residents (#50, #68) of two residents reviewed for oxygen/respiratory therapy. The census was 53. Findings Include: 1. Record review of Resident #50's medical record revealed medical diagnoses of hypertensive heart disease with heart failure, chronic diastolic heart failure, and cerebral infarction with residual deficits. The resident had a BIMS score of 12. Observation on 09/02/25 at 12:09 P.M. of Resident #50's room revealed an uncovered and unlabeled nebulizer mask placed beside a plant on top of the air conditioning unit. Interview on 09/02/25 at 2:30 P.M. with Unit Manager #322 verified the nebulizer mask was uncovered and placed near the plant and on top of the air conditioning unit. Review of the facility's Oxygen Equipment policy dated 09/25/13 revealed nasal cannula, tubing, and mask will be labeled with date when new cannula, tubing or mask applied by Registered Nurse (RN) or Licensed Practical Nurse (LPN). For infection control purposes, all nasal cannulas, oxygen masks, Bi-PAP, C-PAP masks need to have a plastic bag attached for storage when not in use. Bag needs to be changed weekly and dated. Observation of Resident #50's room on 09/04/25 at 3:10 P.M. revealed Resident #50's nebulizer machine on and Resident #50 alone and asleep in chair with nebulizer mask under blanket. Interview with LPN #308 on 09/04/25 at 3:22 P.M. verified the nurse administering the nebulizer treatment should stay with the resident throughout the duration of the treatment. Review of the facility's Medication Administration policy dated 08/07/23 states after administration of the medication to remain with resident until administration of medication is complete. 2. Review of Resident #68's medical record revealed they were admitted to the facility on [DATE]. Diagnoses included periprosthetic fracture around internal prosthetic left hip joint, Chronic obstructive pulmonary disease, concussion, severe protein calorie malnutrition, peripheral vascular disease chronic pain syndrome, anxiety and urinary tract infection. Review of the admission minimum data set (MDS) assessment dated [DATE] revealed her cognition was intact (BIM's 13). She is independent with eating, supervision or touching assistance with oral hygiene and personal hygiene, dependent on toileting, and partial to moderate assistance with bathing. Occasionally incontinent of bowel and bladder. On 09/02/25 at 1:19 P.M. Resident #68's nebulizer was observed on the bedside stand and the tubing and mouthpiece were observed laying on the stand uncovered and was not dated. On 09/02/25 at 1:22 P.M. this was verified during interview with Registered Nurse (RN) #312. Review of the facility policy and procedure dated 08/20/2010 and replace 12/17/23, revealed label and date when a new cannula or mask is applied. For infection control purposes, all nasal cannulas, oxygen masks, BI-PAP, C-PAP, need to be stored in plastic bags when not in use.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of facility policy, the facility failed to ensure non-pharmacological interventions were implemented for pain per care plans for one resident (Resident #67). Additionally, the facility failed to ensure that parameters were in place for pain medication administration for Resident #29. This affected two residents (Resident #29 and #67) out of two residents reviewed for pain management. The facility census was 53 residents. Findings Include: 1. Review of Resident #67's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included CHF, cellulitis of the left lower limb, morbid obesity, atrial fib, diabetes, chronic obstructive pulmonary disease (COPD), fibromyalgia, major depression, anxiety, restless leg syndrome and poly- osteoarthritis. Review of the minimum data set (MDS) assessment revealed it was in progress and not completed due to the resident being a newer admission. Review of the physician's orders revealed Resident #67 had an order dated 08/30/25 for Percocet (narcotic medication) oral tablet 7.5-325 milligrams (mg) (Oxycodone w/ Acetaminophen) one tablet by mouth every six hours as needed for moderate pain. Review of the plan of care dated 09/02/25 revealed to implement non-pharmacological interventions (specify) music, art, drama therapy, exercise, therapeutic modalities (e-stim, TENS, cryotherapy, thermal therapy, biofeedback), acupuncture, acupressure, massage, ultrasound, relaxation techniques, counseling, warm/cool compress, positioning, to assist with pain and monitor for effectiveness. On 09/04/25 review of the progress notes and the medication administration record revealed no documentation of non-pharmacological interventions. On 09/04/25 at 9:50 A.M. interview with Corporate Registered Nurse #415 verified no documented evidence of non-pharmacological interventions. 2. Review of Resident #29's medical record revealed that she was admitted to the facility on [DATE]. Diagnoses for Resident #29 included focal traumatic brain injury, moderate protein calorie malnutrition, chronic pain syndrome, and systemic lupus. Review of Resident #29's most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed that Resident #29 had a Brief Interview for Mental Status (BIMS) score of 15, indicative of intact cognition. She was assessed as requiring substantial/ maximal assistance for personal hygiene and was dependent for mobility. Resident #29 was assessed as having frequent pain and taking opioid medication. Review of Resident #29's physician orders dated 08/26/25 revealed that Resident #29 had physician orders dated 08/16/25 revealed that she was to have Oxycodone HCl oral tablet 20 mg one tablet as needed for pain every four hours. Resident #29 was also ordered Morphine Sulfate oral tablet 15 mg as needed every four hours for pain. There were no parameters for pain in place for the indicators for administration for Oxycodone HCl and Morphine Sulfate. Review of Resident #29's August 2025 Medication Administration Record (MAR) revealed that there were no parameters for pain for as needed Oxycodone HCl medication and that the medication was given on the following dates: 08/16/25, 08/17/25, 08/18/25, 08/19/25, 08/20/25, 08/21/25, (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	08/22/25, 08/23/25, 08/24/25, 08/25/25, and 08/26/25. Review of Resident #29's August 2025 MAR revealed that there were no parameters for pain as needed for Morphine Sulfate medication and that the medication was given on the following dates: 08/27/25, 08/28/25, 08/29/25, 08/30/25, and 08/31/25. On 08/27/25 and 08/29/25, Resident #29 had a pain level of zero and morphine sulfate was administered. An interview with Regional Nurse #415 on 09/04/25 at 9:50 A.M. confirmed that Resident #29 did not have pain parameters in place for Oxycodone HCl and Morphine Sulfate for her as needed medication. A follow up interview with Regional Nurse #415 on 09/04/25 at 11:27 A.M. revealed that she clarified the pain level parameters in the orders for the as needed pain medication for Resident #29. Review of the facility policy dated 03/01/10 and revised on 04/18/24 titled, Pain Management, revealed that pain is evaluated and documented using a consistent approach using a consistent approach and standard pain assessment instrument appropriate to their cognitive status. Approaches include a numeric rating scale or a verbal descriptor scale for residents that have no cognitive impairment to moderate cognitive impairment. Treatments will include non-pharmacological treatments including environmental, physical, cognitive, behavioral or spiritual interventions.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, review of the pharmacist's medication regimen reviews, staff interviews, the facility failed to ensure that appropriate rationale was given for not attempting a gradual dosage reduction for an antidepressant medication. This affected one resident (Resident #9) out of five residents reviewed for unnecessary medications. The facility census was 53 residents. Findings Include: Review of Resident #9's medical record revealed that the resident was admitted to the facility on [DATE] and had diagnoses that included cerebral infarction, dementia, depression, and schizoaffective disorder. Review of Resident #9's most recent comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed that she had a Brief Interview for Mental Status (BIMS) of 07, indicative of severe cognitive impairment. Resident #9 was assessed as requiring partial to moderate assistance with toileting hygiene, showering assistance and mobility. She was assessed as taking antidepressant medication. Review of the Medication Regimen Review dated 10/25/24 revealed that the consultant pharmacist recommendations to the physician stated that Resident #9 was on Duloxetine 60 mg one capsule daily. A proposed change for a gradual dosage reduction to Duloxetine be made as a trial decrease of Duloxetine to 40 mg one tablet daily. The physician wrote no change as a response on 11/01/24 but did not give rationale as to why a gradual dosage reduction for Duloxetine would not be attempted. An interview with the Director of Nursing on 09/04/25 at 9:08 A.M. revealed that the recommendations from the pharmacist on 10/25/24 and the subsequent response from the physician on 11/01/24 for a gradual dosage reduction trial of Duloxetine did not include appropriate rationale for declining a gradual dosage reduction trial.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on record review and interview the facility failed to ensure a resident was free from significant medication errors when an accurate medication reconciliation was not conducted upon the resident's return to the facility from the hospital. This affected one (Resident #69) out of three residents reviewed for facility admissions. The facility census was 53. Findings Include: Review of the medical record for Resident #69 revealed an admission date of 07/10/25, a readmission date of 08/12/25 and a discharge home date of 08/19/25. Diagnoses included metabolic encephalopathy, acute kidney failure, heart disease, chronic diastolic heart failure (CHF), major depressive disorder and paroxysmal atrial fibrillation. Review of the discharge Minimum Data Set (MDS) 3.0 assessment completed 08/19/25 revealed Resident #69 is cognitively intact, has active diagnoses of CHF and is receiving anticoagulant therapy. Review of the after-visit summary for the hospital stay from 08/08/25 through 08/12/25 revealed the medication list included an order for Eliquis (anticoagulant medication) 5 mg, one tablet by mouth twice daily, with the last administration documented on 08/12/25 at 8:41 A.M. Review of the care plan dated 08/13/25 revealed Resident #69 has altered cardiovascular status related to chronic heart failure, hypertension, atrial fibrillation and coronary artery disease. Interventions include administering medications per physician orders, monitoring for chest pain and obtaining vital signs as needed. Review of the physician order dated 08/15/25 at 7:01 P.M. revealed a phone order was received for Eliquis 5 mg, one tablet by mouth twice daily for atrial fibrillation. Review of the Medication Administration Record (MAR) revealed Eliquis 5 mg by mouth twice daily for atrial fibrillation was initiated and given on 08/15/25 at 9:00 P.M. Interview on 09/04/25 at 4:16 P.M. with the Director of Nursing (DON) revealed nursing staff did not complete a thorough and accurate medication reconciliation upon the resident's readmission. As a result, Eliquis was not included in the physician orders. The DON confirmed Eliquis was not ordered until 08/15/25, three days after the resident's return to the facility. This deficiency represents non-compliance investigated under Complaint Number 2600930.		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and interview the facility failed to ensure dental recommendations and prior authorization was submitted in a timely manner. This affected one (Resident #46) out of two residents reviewed for ancillary services. The facility census was 53. Findings Include: Review of the medical record for Resident #46 revealed an admission date of 12/16/22 with diagnoses including chronic respiratory failure with hypoxia, major depressive disorder, chronic pain syndrome, and gastroesophageal reflux disease without esophagitis. Review of the care plan dated 02/16/23 revealed the resident had oral/dental health concerns due to the absence of upper teeth and the presence of some natural lower teeth. Interventions included monitoring and reporting oral health issues and providing dental consults as needed. Review of the dental visit dated 01/08/25 revealed a referral for extraction of the remaining upper and lower teeth. Review of the Medicaid denture prior authorization request dated 01/13/25 revealed the dental provider recommended submitting the treatment plan to Medicaid for approval. The proposed treatment included full upper and lower dentures to improve chewing function and would be performed at no cost to the resident or responsible party. Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #46 is cognitively intact, independent with oral hygiene, and had no broken natural teeth. Interview on 09/02/25 at 11:20 A.M. with Resident #46 revealed she recalled a dental visit earlier in the year where extractions were recommended so she could receive dentures. She stated she spoke with a male staff member at the facility regarding the service but had not received a date for a follow-up appointment. Interview on 09/04/25 at 8:47 A.M. with Licensed Social Worker #212 confirmed the resident had a dental appointment on 01/08/25 with a recommendation to remove upper and lower teeth. He stated he assists with dental coordination but acknowledged that neither he nor anyone else had followed up to schedule the recommended procedures or submit authorization. He confirmed no progress had been made on the dental recommendations and a call to the dentist office was made for additional information. Review of an undated letter from the dental health service revealed that on 01/08/25, Resident #46 was seen for an initial examination, prophylaxis, and a full series of x-rays. At that visit, the clinical team recommended a treatment plan for full upper and lower dentures, along with a referral to an oral surgeon for removal of all remaining teeth, root tips, and [NAME] to allow for denture construction. The dental office reported that no treatment authorizations had been received, and therefore no appointments had been scheduled to proceed with the treatment plan. Review of email communication from the social worker to the dental health service dated 09/04/25 revealed the signed prior authorization was sent for Resident #46. Interview on 09/04/25 at 12:18 P.M. with the Administrator confirmed the prior authorization was sent on 09/04/25 to the dentist office after eight months after the initial recommendation was made. Interview on 09/04/25 at 2:00 P.M. with Resident #46 confirmed the licensed social worker had recently spoken with her about the appointment and informed her they were working on submitting the necessary paperwork. Review of Ancillary - Additional Services and Fees policy (dated 02/14/12) revealed when additional services are desired, the completed paper work will be copied and given to the social worker to arrange for services.		

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F 0948 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that paid feeding assistants have the training they need. Based on observation, interview, record review, and facility policy review the facility failed to ensure staff who were competent/certified were assisting residents with feeding. This affected one resident (#16) of three residents observed being assisted with eating by staff. The census was 53. Findings Include: Review of Resident #16's medical record revealed an admission date of 04/24/20. Diagnoses included Alzheimer's disease with late onset, gastro-esophageal reflux disease without esophagitis and unspecified severe protein-calorie malnutrition. Review of Resident #16's care plan focus dated 11/30/22 stated Resident #16 had a risk for aspiration related to diagnosis of dysphagia. Interventions included assist with meals, feed at times, do not leave alone. The positions noted to oversee this intervention are listed as Certified Nursing Aide (CNA or STNA), Registered Nurse (RN), and Licensed Practical Nurse (LPN). Observation on 09/03/25 at 8:30 A.M. revealed [NAME] Manager #321 assisting Resident #16 with eating in the resident's room. Interview on 09/03/25 at 11:06 A.M. with [NAME] Manager #321 verified she was feeding Resident #16 for breakfast and was not a certified feeding assistant or certified nursing aide. Review of the facility's Feeding the Impaired Resident Policy, dated 08/24/2010, revealed the roles responsible for feeding impaired residents are Registered Nurse (RN), Licensed Practical Nurse (LPN) and State Tested Nurse Aide (STNA or CNA).		