STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366143	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adams County Manor	10856 State Route 41 West Union, OH 45693

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 and staff interview, the facility failed to store food in a manner to prevent food born illness. This had to potential to affect all 69 residents residing in the facility who received food from the kitchen. The facility census was 69 residents.Findings include: 1.Observation on 03/23/26 at 9:21 A.M. of the dry storage area revealed there was a box of dried onion flakes in a bag which was unsealed and open to air. Interview on 03/23/25 at 9:22 A.M. with the Dietary Manager (DM) confirmed the onion flakes were not properly sealed and should have been discarded. 2.Observation on 03/23/26 at 9:23 A.M. of stand-up freezer #1 revealed it contained an undated bag of flour tortillas which were open to air and were undated and unlabeled and an undated and unlabeled milkshake. Interview on 03/23/26 at 9:24 A.M. with the DM confirmed the tortillas were not dated nor properly sealed and should have been discarded. The DM confirmed the milkshake was undated and unlabeled and should have been discarded. 3. Observation on 03/23/26 at 9:27 A.M. of kitchenette next to main kitchen refrigerator revealed it contained the following unlabeled and undated items: a bag of visibly spoiled lettuce, a package of cheese, a box of hamburgers. Interview on 03/23/26 at 9:28 A.M. with the DM confirmed the lettuce, cheese, and hamburgers in the refrigerator were unlabeled and undated and should have been discarded. 4. Observation on 03/23/26 at 9:29 A.M. of stand-up refrigerator #1 revealed it contained a bag of turkey lunchmeat and a bag of ham lunchmeat both unsealed and open to air. Interview on 03/23/26 at 9:30 A.M. with the DM confirmed the turkey and ham were not properly sealed and should have been discarded. 5. Observation on 03/23/26 at 9:42 A.M. of stand-up freezer #2 revealed it contained two thermometers which read 48 degrees Fahrenheit (F). The freezer contained individually packaged servings of orange juice, prune juice, and apple juice in boxes labeled to keep the juices at temperatures below 38 degrees F. The freezer also contained boxes of individually wrapped dinner rolls and doughnuts. Interview of 03/23/26 at 9:43 A.M. with the DM confirmed the freezer temperature was 48 degrees F and needed to be repaired or replaced and the facility was awaiting estimates regarding the cost of the repair. The DM further confirmed the instructions for the juices indicated they were to be stored below 38 degrees F. Interview on 03/26/26 at 3:10 P.M. with the Administrator confirmed he was aware there was a freezer in the kitchen that was being looked at to repair or replace but he was unaware that food and beverages were being stored in it. 6. Observation on 03/23/26 at 9:47 A.M. of stand-up refrigerator #4 revealed it contained an unsealed bag of cheese and a bag of thawed frozen strawberries with an open date of 03/07/26. Interview on 03/23/26 at 9:48 A.M. with the DM confirmed the cheese was not properly sealed and the strawberries had expired and both items should have been discarded. 7.Observation on 03/23/26 at 9:50 A.M of freezer #3 revealed it contained a bag of chicken fingers unsealed and open to air. Interview on 03/23/26 at 9:51 A.M. with the DM confirmed the chicken fingers were not properly sealed and should have been discarded. 8. Observation on 03/26/26 at 12:16 P.M of the refrigerator in the therapy gym used to store resident food revealed it contained meat and crackers labeled with a resident name but undated and a premade salad in a takeout container unnamed and undated. Observation of the freezer compartment revealed it contained a partially consumed milkshake open to air with no name of date and a half-gallon container of vanilla ice cream opened, (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	unnamed and undated. Interview on 03/26/26 at 12:17 P.M. with Therapy Manager (TM) #97 confirmed the items in the refrigerator/freezer were not properly labeled and dated and should have been discarded.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, resident interview, staff interview, and review of facility policy, the facility failed to ensure resident shower floors were maintained in good repair. This affected four (Residents #10, #11, #35, and #38) of the 24 residents sampled for showers. The facility census was 69 residentsFindings include: Observation on 03/23/26 at 1:16 P.M. revealed the shower floor in Resident #10 and Resident #11's bathroom had a large amount of water pooled on top of the tiles. Several floor tiles were cracked, grout was missing between multiple tiles, and the surface of the tiles was uneven. Observation on 03/26/26 at 9:00 A.M. revealed the shower floor in the room of Resident #35 and Resident #38's bathroom had multiple broken and/or missing tiles, and the surface of the tiles was uneven. Interview on 03/26/26 at 9:01 A.M with Resident #35 confirmed multiple tiles on the shower floor were missing or broken and the water did not drain well. Interview on 03/26/26 at 9:10 A.M with Certified Nursing Assistant (CNA) #562 confirmed the shower floors in Resident #10, #11, #35, and #38's bathrooms had missing, cracked, and broken tiles and confirmed the water did not drain correctly from the showers causing water to pool on the shower floors after the residents' showers. Review of the facility policy titled Homelike Environment undated revealed the facility encouraged the personalization and comfort of a home-like environment. This deficiency represents noncompliance investigated under Complaint Number 2647177.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on medical record review and staff interview, the facility failed to ensure appropriate monitoring of target behaviors for residents receiving antipsychotic medications. This affected two (Residents #6 and #20) of five residents reviewed for unnecessary medications. The facility census was 69 residents.Findings include:1.Review of the medical record for Resident #6 revealed an admission date of 04/17/23 with diagnoses including acute kidney failure, psychotic disorder, anxiety disorder, and bipolar disorder. Review of the physician's order for Resident #6 revealed an order dated 11/19/25 for Abilify (an antipsychotic medication) 10 milligrams (mg) by mouth once a day at bedtime related to psychotic disorder with hallucinations. Review of the Minimum Data Set (MDS) assessment for Resident #6 dated 12/16/25 revealed the resident was cognitively intact and received antipsychotic medication. Review of the medical record for Resident #6 revealed it did not include target behaviors and/or monitoring of behaviors related to the administration of Abilify. Interview on 03/26/26 at 12:10 P.M with Assistant Director of Nursing #490 confirmed facility staff had not identified or monitored target behaviors related to the administration of Abilify for Resident #6. 2. Review of the medical record for Resident #20 revealed an admission date of 12/17/24 with diagnoses including Wernicke's encephalopathy, alcohol abuse, psychotic disorder with hallucinations, and dementia. Review of the MDS assessment for Resident #20 dated 12/22/25 revealed the resident was was cognitively intact and received antipsychotic medication. Review of the physician's order for Resident #20 revealed an order dated 02/12/26 for Zyprexa (an antipsychotic medication 7.5 mg by mouth once a day at bedtime related to Wernicke's encephalopathy. Review of the medical record for Resident #20 revealed it did not include target behaviors and/or monitoring of behaviors related to the administration of Zyprexa. Interview on 03/24/26 at 1:50 P.M. with the Director of Nursing confirmed facility staff had not identified or monitored target behaviors related to the administration of Zyprexa for Resident #20.

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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 medical record review, observation, and staff interview, the facility failed to ensure Minimum Data Set (MDS) assessments were coded to accurately reflect immunizations and restraint use. This affected two (Residents #11 and #20) of 24 sampled residents. The facility census was 69 residents.Findings include:1.Review of the medical record for Resident #11 revealed an admission date of 02/14/25 with diagnoses including dementia, mood disorder, and anxiety disorder. Review of the physician's orders for Resident #11 revealed an order dated 09/26/25 for bilateral handrails to promote bed mobility due to weakness. Check placement every shift. Review of the Minimum Data Set (MDS) assessment section P for Resident #11 dated 02/24/26 revealed bed rails were coded as a physical restraint which was used daily. Review of the care plan for Resident #11 revealed it did not include documentation of restraint use for the resident. Review of the medical record for Resident #11 revealed it did not include a restraint assessment. Observation on 03/23/26 at 1:12 P.M. revealed Resident #11's bed had two small handrails attached to each side of the top of the resident's bed to utilize for bed mobility. The handrails did not inhibit the resident's movement in or out of the bed or otherwise restrain the resident. 2. Review of the medical record for Resident #20 revealed an admission date of 12/17/24 with diagnoses including Wernicke's encephalopathy, psychotic disorder with hallucinations, and dementia. Review of the vaccine consent form for Resident #20 dated 09/29/25 revealed the resident was offered and declined the pneumonia vaccine. Review of the MDS assessment for Resident #20 dated 12/22/25 revealed the resident was not up to date with the pneumonia vaccine due to the vaccine not being offered. Interview on 03/26/26 at 9:55 A.M. with Assistant Director of Nursing (ADON) #490 and MDS Nurse #514 on confirmed Resident #11 had handrails ordered for mobility purposes which were not assessed to restrain the resident and the MDS assessment dated [DATE] had been coded inaccurately. ADON #490 and MDS #514 additionally confirmed Resident #20 had been offered the pneumonia vaccine on 09/29/25 and had declined the vaccine and the MDS assessment dated [DATE] had been coded inaccurately.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on medical record review and staff interview, the facility failed to ensure Pre-admission Screening and Resident Reviews (PASARRs) were completed and updated to reflect new qualifying diagnoses. This affected one (Resident #66) of four residents reviewed for PASARR accuracy. The facility census was 69 residents. Findings include: Review of the medical record for Resident #66 revealed an admission date of 05/14/23 with diagnoses including diabetes mellitus type two, depression, and mood disorders, and osteomyelitis. Review of the most recent PASARR for Resident #66 dated 06/08/23 revealed it did not include a diagnosis of bipolar disorder type two. Review of the diagnosis list for Resident #66 revealed a new mental health diagnosis of bipolar disorder type two was added on 08/20/25. Review of the Minimum Data Set (MDS) assessment for Resident #66 dated 01/12/26 revealed the resident had moderately impaired cognition. Interview on 03/25/26 at 11:43 A.M. with Corporate Director of Nursing #99 verified the facility had not completed a new PASARR for Resident #66 following the addition on 08/20/25 of a new mental health diagnosis for the resident.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on medical record review and staff interview, the facility failed to develop a plan of care for residents who received oxygen on a continuous basis. This affected one (Resident #66) of 21 residents reviewed for care plans. The facility census was 69 residents.Findings include: Review of the medical record for Resident #66 revealed an admission date of 05/14/23 with diagnoses including diabetes mellitus type two, depression, and mood disorders, and osteomyelitis. Review of the Minimum Data Set (MDS) assessment for Resident #66 dated 01/12/26 revealed the resident had moderately impaired cognition. Review of the care plan for Resident #66 last revised on 03/07/26 revealed there was no care plan to address the resident's care needs related to supplemental oxygen and oxygen use. Review of the physician's orders for Resident #66 revealed an order dated 03/09/26 for oxygen at two to three liters per minute per nasal cannula to maintain oxygen saturation levels above 90 percent (%) every day and night shift. Interview on 03/25/26 at 11:43 A.M. with Corporate Director of Nursing (DON) #99 verified the facility did not develop a care plan to address Resident #66's care needs related to supplemental oxygen and oxygen use.

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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 medical record review, observation, resident interview, staff interview, and review of the facility policy, the facility failed to ensure staff provided timely bathing and hair washing assistance for dependent residents. This affected one (Resident #8) of the three residents reviewed for activities of daily living (ADL) assistance. The facility census was 69 residents. Findings include:Review of the medical record for Resident #8 revealed an admission date of 11/27/25 with diagnoses including acute kidney failure, adult failure to thrive, and depression. Review of the Minimum Data Set (MDS) assessment for Resident #8 dated 11/27/25 revealed the resident was cognitively intact. Review of the care plan for Resident #8 dated 12/11/25 revealed the resident was at risk for a self-care deficit with bathing, dressing, and feeding. Interventions included the following: encourage the resident to participate in planning day to day care, evaluate the resident's ability to perform self-care, minimize environmental stimuli, provide assistance with ADLs as needed. Review of the shower task list for Resident #8 initiated 11/27/25 revealed the resident was scheduled to receive showers on night shift on Sundays and Thursdays. Review of the shower documentation for Resident #8 dated 02/26/26 through 03/25/26 revealed the resident received showers on 03/06/26 and 03/22/26. There were no additional showers documented during the 30-day time frame. Observation on 03/24/26 at 8:45 A.M. of Resident #8 revealed the resident's hair was greasy and appeared unwashed. Interview on 03/24/26 at 8:46 A.M. with Resident #8 confirmed she preferred to have a shower or bed bath at least twice a week and to have her hair washed on those days. Resident #8 confirmed she had not had her hair washed in weeks and did not receive a shower or bed bath at least twice a week per her preference. Observation on 03/26/26 at 9:05 A.M. of Resident #8 revealed the resident's hair was greasy and appeared unwashed. Interview on 03/26/26 at 9:06 A.M. with Resident #8 confirmed she had still not received a shower or had her hair washed. Interview 03/26/26 at 10:50 A.M. with the Director of Nursing (DON) confirmed residents should receive showers and hair washing per their scheduled preference and staff were to document the showers and care in the resident's medical record. The DON confirmed Resident #8 was documented to have received two showers or bed baths from 02/26/26 through 03/25/26 and was not documented to have refused any care. Review of the facility policy titled Supporting Activities of Daily Living revised March 2018 revealed residents who were unable to carry out ADLs independently would receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. This deficiency represents noncompliance investigated under Complaint Number 2647177.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on medical record review, staff interview, and review of facility policy, the facility failed to ensure staff obtained resident weights as ordered by the physician. This affected one (Resident #12) of five residents reviewed for nutrition. The facility census was 69 residents.Findings include:Review of the medical record for Resident #12 revealed an admission date of 02/02/26 with diagnoses including adult failure to thrive, chronic obstructive pulmonary disease (COPD), and protein calorie malnutrition. Review of the physician's orders for Resident #12 revealed an order dated 02/02/26 for the resident to be weighed every Monday, Wednesday, and Friday at 6 A.M. due to COPD. Review of the Minimum Data Set (MDS) assessment for Resident #12 dated 02/11/26 revealed the resident had severely impaired cognition. Review of the weight record for Resident #12 dated February 2026 and March 2026 revealed weights were not documented on the following dates: 02/06/26, 02/09/26, 02/11/26, 02/16/26, 02/18/26, 02/20/26, 02/23/26, 02/25/26, 03/02/26, 03/04/26, 03/09/26, 03/11/26, 03/13/26, 03/16/26, 03/18/26, 03/23/26. There was no documentation of resident refusal of weights. Interview on 03/26/26 at 10:30 A.M with the Director of Nursing (DON) confirmed Resident #12 had a physician's order to be weighed every Monday, Wednesday, and Friday at 6:00 A.M. due to COPD. The DON confirmed the facility had no documented weights or refusals of weights for the following dates in February 2026 and March 2026: 02/06/26, 02/09/26, 02/11/26, 02/16/26, 02/18/26, 02/20/26, 02/23/26, 02/25/26, 03/02/26, 03/04/26, 03/09/26, 03/11/26, 03/13/26, 03/16/26, 03/18/26, 03/23/26 Review of the facility policy titled Weights Policy and Procedure undated revealed the facility staff would weigh all residents upon admission and weekly for four weeks and then monthly after admission unless specific diagnoses indicated a daily weight. Additional weights might be requested by the dietitian, physician or nursing staff as needed. All resident weights should be recorded in the weight/vital section of the electronic medical record.

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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. Based on medical record review, staff interview, resident interview, and review of facility policy, the facility failed to ensure staff routinely monitored resident pain levels. This affected one (Resident #20) of five residents reviewed for unnecessary medications. The facility census was 69 residents.Findings include:Review of the medical record for Resident #20 revealed an admission date of 12/17/24 with diagnoses including Wernicke's encephalopathy, psychotic disorder with hallucinations, and dementia. Review of the care plan for Resident #20 dated 05/15/25 revealed the resident was at risk for pain/discomfort. Interventions included the following: administer medications as ordered/as warranted, monitor for effectiveness, assess the resident's pain/location/duration/frequency/intensity and document negative findings. Review of the physician's orders for Resident #20 revealed an order 07/23/25 for Tylenol two 325 milligram (mg) tablets every six hours for left hip pain. Review of the Minimum Data Set (MDS) assessment for Resident #20 dated 12/22/25 revealed was cognitively intact and had occasional pain which made it hard to sleep during five days of the review period. Review of the Medication Administration Records (MARs) for Resident #20 dated February 2026 and March 2026 revealed there was no order for routine pain monitoring and there was no documentation of pain assessment since 02/25/26. Interview on 03/24/26 at 1:50 P.M. with the Director of Nursing (DON) confirmed all residents should have a set day when their pain assessment was to be completed. The DON confirmed Resident #20's medical record did not include a physician's order for routine pain monitoring and the resident's MARS dated February 2026 and March 2026 had no documented pain assessment since 02/25/26. Interview on 03/26/26 at 9:22 A.M. with Resident #20 confirmed his pain level fluctuated but was manageable, and he received scheduled medication for pain which was typically effective. Review of the facility policy titled Pain Management and Assessments undated, revealed all residents would be monitored for pain every shift by nursing and this information should be tracked on the pain section of the resident's MAR flow sheet.