STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366187	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Minerva Rehabilitation and Nursing Center	1035 East Lincolnway Minerva, OH 44657

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review, staff interview and facility policy review, the facility failed to ensure comprehensive care plans were developed timely for Residents #4, #7, #16, #18, and #24. This affected five residents (#4, #7, #16, #18, and #24) of 15 residents reviewed for care plans. The facility census was 16.Findings include:1. Record review for Resident #7 revealed an admission date of 11/20/25 with diagnoses of Alzheimer's disease, senile degeneration of the brain, anxiety disorder, major depressive disorder, and unspecified psychosis. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #7 was cognitively impaired and was receiving hospice services. Review of Resident #7's interim care plan assessment, dated 11/20/25, revealed hospice/end of life care provided. Review of Resident #7's comprehensive care plan, dated 11/20/25, revealed no hospice care plan. Interview on 01/20/26 at 4:23 P.M. with Licensed Practice Nurse (LPN) #211 revealed hospice residents had a hospice order and care plan in their chart. LPN #211 indicated the hospice order and care plan would have to be verified as they couldn't be located. Interview on 01/21/26 at 12:10 P.M. with the Director of Nursing (DON) confirmed Resident #7 did not have a hospice care plan. The DON revealed the hospice care plan was added to Resident #7's comprehensive care plan on 01/20/26 as a care plan audit was completed. Review of facility's policy titled Care Planning-Interdisciplinary Team, revised 09/13, a comprehensive care plan for each resident is developed within seven days of completion of the resident assessment (MDS). The care plan is based on the resident's comprehensive assessment and is developed by an interdisciplinary team. 2. Record review for Resident #18 revealed an admission date of 10/07/25 with diagnoses of cerebral infarction, chronic obstructive pulmonary disease, type I diabetes, and anxiety. Review of the interim care plan assessment, dated 10/07/25, revealed Resident #18 was not a current smoker. Review of Resident #18's comprehensive care plan, dated 10/07/25, revealed no smoking care plan. Review of the admission MDS 3.0 assessment dated [DATE] revealed Resident #7 was cognitively (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	impaired, and no tobacco use was listed. Review of the smoking assessment, dated 11/04/25, revealed Resident #18 was safe to smoke with supervision. Interview on 01/21/26 at 10:34 A.M. with the Administrator revealed Resident #18 had a history of smoking but was not smoking until after she was admitted when a family member was smoking. Interview on 01/21/26 at 12:10 P.M. with the DON confirmed Resident #18 did not have a smoking care plan. The DON revealed the smoking care plan was added to Resident #18's comprehensive care plan on 01/21/26 as a care plan audit was completed. Review of the undated Smoking policy revealed any smoking-related privileges, restrictions, and concerns shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. Review of facility's policy titled Care Planning-Interdisciplinary Team, revised 09/13, a comprehensive care plan for each resident is developed within seven days of completion of the resident assessment (MDS). The care plan is based on the resident's comprehensive assessment and is developed by an interdisciplinary team. 3. Review of the medical record for Resident #4 revealed an admission date of 10/30/25 with diagnoses that included urinary tract infection, stroke, cognitive communication deficit, insomnia, and anxiety. Review of the MDS 3.0 admission assessment dated [DATE] revealed Resident #4 was moderately cognitively impaired, did not reject care, and needed maximal assistance with activities of daily living. Review of the elopement assessment dated [DATE] revealed Resident #4 was a high risk for elopement due to ambulatory status, intermittent confusion, and having resided in the facility for 30-120 days. Review of the care plan dated 12/14/25 revealed the absence of elopement interventions. Review of the physician orders for Resident #4 revealed an order for elopement precautions to monitor for wandering and exit seeking behaviors, and no unsupervised leave of absence's due to being an elopement risk. The orders were dated 12/14/25. An interview on 01/22/26 at 10:05 A.M. with LPN #208 verified Resident #4 was categorized as high risk for elopement related to the assessment, and the care plan was absent of elopement interventions. Review of facility's policy titled Care Planning-Interdisciplinary Team, revised 09/13, a comprehensive care plan for each resident is developed within seven days of completion of the resident assessment (MDS). The care plan is based on the resident's comprehensive assessment and is developed by an interdisciplinary team. 4. Review of the medical record for Resident #24 revealed an admission date of 01/14/26 with diagnoses that included pneumonia, urinary tract infection, heart failure, bacteremia (bacteria in the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	blood), and respiratory failure. Review of the interim care plan dated 01/15/26 revealed Resident #24 needed assistance with activities of daily living. Review of the Brief Interview for Mental Status (BIMS) dated 01/16/26 revealed Resident #24 was moderately cognitively impaired. Review of the physician orders revealed Resident #24 had an order to change PICC dressing per protocol, measure the external length of the peripherally inserted central catheter (PICC), an intravenous catheter that extends from a vein in the arm into the large vein just before the heart often used for long term antibiotic administration, in centimeters (cm), and measure the upper arm circumference in cm at the insertion site. All orders were dated 01/16/26. An observation on 01/21/26 at 10:22 A.M. revealed Resident #24 had a PICC line. Review of current the care plan for Resident #24 revealed the absence of PICC-related interventions. An interview on 01/22/26 at 10:19 A.M. with LPN #208 verified the absence of PICC-related interventions in the care plan. Review of facility's policy titled Care Planning-Interdisciplinary Team, revised 09/13, a comprehensive care plan for each resident is developed within seven days of completion of the resident assessment (MDS). The care plan is based on the resident's comprehensive assessment and is developed by an interdisciplinary team. 5. Review of the medical record for Resident #16 revealed an admission date of 12/24/25. Diagnoses included cellulitis of left lower limb, type II diabetes mellitus, morbid obesity due to excess calories, difficulty in walking, lack of coordination, unspecified injury of kidney, atherosclerotic heart disease of native coronary artery without angina pectoris, acute diastolic heart failure, chronic embolism and thrombosis, obstructive sleep apnea, benign prostatic hyperplasia without lower urinary tract symptoms, essential hypertension, chronic pain syndrome, anemia, and cannabis abuse. Review of a care plan dated 12/24/25 for Resident #16 failed to reveal a focus of care for central line or peripherally inserted central catheter (PICC). Review of the medical record for Resident #16 revealed a MDS 3.0 assessment dated [DATE] revealed BIMS score of 15 on a 0-15 scale, indicating the resident was cognitively intact. The resident required some assistance with activities of daily living. On 01/20/26 at 10:20 A.M., an observation of Resident #16 revealed a central line catheter, which he called a PICC line to his right upper chest. The line was not accessed. He reported he had been getting intravenous antibiotics through the line; however, now it was just being flushed daily, and he got dressing changes to it weekly. An interview with the DON on 01/22/26 at 1:13 P.M. revealed there was no focus of care for a PICC line for Resident #16. She further confirmed the resident had orders for PICC line care and interventions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility's policy titled Care Planning-Interdisciplinary Team, revised 09/13, a comprehensive care plan for each resident is developed within seven days of completion of the resident assessment (MDS). The care plan is based on the resident's comprehensive assessment and is developed by an interdisciplinary team.

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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. Based on record reviews, observations, interviews and facility policy review, the facility failed to respect the dignity of residents by failing to empty a urinal in full view of the hallway or cover a urinary catheter drainage bag. This affected two (Resident #16 and Resident #3) of two residents reviewed for dignity and respect. The facility census was 16.Findings include:1. Review of the medical record for Resident #16 revealed an admission date of 12/24/25. Diagnoses included cellulitis of left lower limb, type two diabetes mellitus, morbid obesity due to excess calories, difficulty walking, lack of coordination, unspecified injury of the kidney, atherosclerotic heart disease of native coronary artery without angina pectoris, acute diastolic heart failure, chronic embolism and thrombosis, obstructive sleep apnea, benign prostatic hyperplasia without lower urinary tract symptoms, essential hypertension, chronic pain syndrome, anemia, and cannabis abuse. Review of the medical record for Resident #16 revealed a Minimal Data Set (MDS) 3.0 assessment, dated 01/05/26, revealed a Brief Interview of Mental Status (BIMS) score of 15 on a 0-15 scale. A score of 15 indicated Resident #16 was cognitively intact. The resident required some assistance with activities of daily living.On 01/20/26 at 9:20 A.M., an observation of Resident #16's room revealed a urinal which was half full of urine. The urinal was on the over-the-bed table, in full view of the hallway.On 01/20/26 at 10:14 A.M., an observation of Licensed Practical Nurse (LPN) #211 revealed she passed by the urinal to care for another resident. After care of the other resident, she walked out of the room and did not remove or empty the urinal. This was confirmed by LPN #211 on 01/20/26 at 11:00 A.M.On 01/20/2026 at 10:18 A.M., an observation and interview with Resident #16 confirmed a urinal, half full, sitting on the over-the-bed table in full view of the hallway, had been there for several hours. This was confirmed by LPN #211 on 01/20/26 at 11:00 A.M.On 01/20/26 at 11:00 A.M., an interview with LPN #211 confirmed the half full urinal could be seen from the hallway for Resident #16. She further confirmed she had entered and exited the room, passing the urinal each time, and had not emptied it.2. Review of the medical record for Resident #3 revealed an admission date of 03/04/25. Diagnoses included chronic obstructive pulmonary disease, muscle wasting, unsteadiness, dysphagia, history of urinary tract infection, depression, metabolic encephalopathy, and malignant neoplasm of the prostate. Review of the MDS 3.0 assessment, dated 12/31/25, revealed a BIMS score of 10 on a 0-15 scale, indicating Resident #3 had moderate cognitive impairment. The resident had a Foley catheter for urinary elimination.On 01/20/2026 10:55 P.M., an observation of Resident #3 revealed a Foley catheter. The catheter bag was half full and uncovered, exposed to the rest of the room. This was confirmed by LPN #211 at the time of the observation.On 01/20/26 at 11:40 A.M., an interview with LPN #211, revealed Resident #3 had a Foley catheter. She confirmed it was uncovered and exposed to the room. She further indicated she had since covered it.On 01/20/26 at 2:15 P.M., an interview with the Director of Nursing (DON) revealed urinals should not be left in view of the hallway and should be emptied as soon as the staff notice the urinal has urine in it. She further confirmed all Foley catheter drainage bags should be covered at all times to protect the resident's dignity.Review of a facility policy titled Quality of Life-Dignity, dated 2001, revealed each resident would be cared for in a manner which promoted and enhanced quality of life, dignity, respect and individuality. The policy explained demeaning practice and standards of care which compromised dignity were prohibited. Such practices included keeping urinary bags covered and responding to residents' requests for toileting assistance.

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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 Based on record review and interview, the facility failed to provide a complete and accurate baseline care plan for Resident #25. This affect one resident (#25) of 15 residents reviewed for care plans. The facility census was 16.Findings include:Review of the medical record for Resident #25 revealed an admission date of 01/14/26. Diagnoses included chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, pneumonia, essential hypertension, anxiety disorder and major depressive disorder. Review of progress notes for Resident #25 revealed an admission note, dated 01/14/26, which indicated the resident had a boney prominence to sacrum which was reddened, but not open, and applied house zinc to the area.Review of a care plan for Resident #25, dated 01/14/26, failed to reveal any evidence of oxygen care planning or interventions. Further, the care plan failed to reveal any evidence of wound care planning or interventions.Review of orders for January 2026 for Resident #25 revealed no oxygen or wound care orders on admission. Review of the Minimum Data Set (MDS) version 3.0 for Resident #25, dated 01/15/26, revealed a Brief Interview for Mental Status (BIMS) score of 13 on a 0-15 scale. A BIMS score of 13 indicated intact cognitive functioning, or normal thinking and memory. The MDS failed to review any wound care needs. The resident needed stand-by assistance for bed mobility and was not able to ambulate without assistance.Review of vital sign documentation for Resident 25 revealed oxygen levels taken daily from 01/14/26 through 01/21/26. The resident was wearing oxygen when the vital signs were taken on all days except 01/14/26 and 01/15/26.On 01/21/26 at 12:24 P.M., an interview with Licensed Practical Nurse (LPN) #211 revealed the care plan for Resident #25 did not contain interventions for wound care or oxygen. She confirmed the resident used oxygen and required care for a pressure ulcer. She further confirmed the admission orders for Resident #25 did not contain orders for oxygen or wound care.

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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 record review, observations, interview and facility policy review, the facility failed to ensure a peripherally inserted central catheter (PICC) line (a long, thin, flexible tube inserted into a vein and threaded into a large vein near the heart) dressing was changed as ordered by the physician for Resident #24. This affected one resident (#24) of five residents reviewed for medication administration. The facility census was 16.Findings include:Review of the medical record for Resident #24 revealed an admission date of 01/14/26 with diagnoses including pneumonia, urinary tract infection, heart failure, bacteremia (bacteria in the blood), and respiratory failure.Review of the interim care plan dated 01/15/26 revealed Resident #24 needed assistance with activities of daily living.Review of the care plan dated 01/15/26 revealed the absence of central line focus and associated interventions.Review of the Brief Interview for Mental Status (BIMS) dated 01/16/26 revealed Resident #24 was moderately cognitively impaired. Review of the physician orders revealed an order dated 01/16/26 to change PICC dressing and caps per protocol.Review of the TAR from 01/14/26 to 01/21/26 revealed absence of documentation the PICC dressing was changed.An observation on 01/21/26 at 10:22 A.M. revealed Resident #24's PICC line dressing was dated as changed on 01/13/26.An observation on 01/21/26 at 2:42 P.M. of antibiotic administration for Resident #24 revealed the same PICC dressing dated 01/13/26.An observation on 01/21/26 at 4:33 P.M. of antibiotic discontinuation for Resident #24 revealed the same PICC dressing dated 01/13/26.An interview on 01/21/26 at 4:39 P.M. with the Covering Director of Nursing (DON) #295 verified PICC dressings should be changed every seven days, and the dressing should have been changed on 01/20/26.Review of the facility policy titled Central Venous Catheter Dressing Changes, dated 04/2016, revealed the purpose of dressing changes are to prevent catheter-related infections and the dressing should be changed every five to seven days.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview, the facility failed to develop and implement a comprehensive and individualized pressure ulcer prevention program for Resident #25. This affected one (Resident #25) of one resident reviewed for pressure ulcers. The facility census was 16.Findings include:Review of the medical record for Resident #25 revealed an admission date of 01/14/26. Diagnoses included chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, pneumonia, essential hypertension, anxiety disorder and major depressive disorder. Review of progress notes for Resident #25 revealed an admission note, dated 01/14/26, which indicated the resident had a boney prominence to the sacrum, which was reddened, but not open, and applied house zinc to the area. Review of the admission physician's orders dated 01/14/26 revealed no wound care orders for Resident #25.Review of a care plan for Resident #25, dated 01/14/26, revealed the resident was to have enhanced barrier precautions (EBP) related to chronic wounds, initiated 01/20/26. The goal was for Resident #25 to remain infection free. Interventions were EBP signage on the door, gloves and gowns for high contact resident care. The care plan failed to reveal any evidence of wound care planning or interventions. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 on a 0-15 scale, indicating Resident #25 was cognitively intact. The MDS was still in progress. Review of progress notes for Resident #25, dated 01/15/26 at 12:07 A.M., revealed a second assessment which indicated her coccyx was red and blanchable and the plan was to continue with house barrier cream and to encourage the resident to turn and reposition. Review of medical record for Resident #25 revealed skilled nursing charting dated 01/16/26, 01/17/26, 01/18/26, which indicated the resident had no open areas on skin. Review of a nursing progress note, dated 01/18/26 at 6:30 P.M., revealed the nurse observed a suspected deep tissue injury (SDTI) to the left buttocks, coccyx, and right buttocks, which had a small amount of bloody drainage noted. A SDTI is a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. The note further read the surrounding skin was pink. No signs and symptoms of infection. Resident #25 spends a majority of her time sitting upright in bed. Resident #25 was noted to be sitting on a cushion while in bed. This nurse encouraged the resident and educated the resident on not sitting on that cushion while in bed and to turn side to side to get off her buttocks. Resident #25 stated that the cushion helps it feel better, and she was not taking it out from under her, and she can't lay side to side due to her breathing issues. The nurse cleansed the area to right buttocks and coccyx with normal saline solution (NSS) and applied dry dressing. The physician was notified and was aware of resident sitting on cushion while in bed. Review of the medical record for Resident #25 revealed a Braden Scale for predicting pressure ulcers, dated 01/18/26, four days after admission. The score of the assessment was 16 on a 0-18 scale. A score of 16 on a Braden scale would indicate the resident was at risk of developing a pressure ulcer. Review of a weekly wound assessment, dated 01/18/26, revealed Resident #25 had a Stage II pressure ulcer. This was documented as Wound #1. A Stage II pressure ulcer is a partial thickness loss of dermis presenting as a shallow open ulcer with a red, pink wound bed, without slough. It may also present as an intact or open/ruptured serum-filled blister. The assessment indicated the wound was on the resident's coccyx and was acquired 01/18/26. Measurements of 1.0 centimeter (cm) in length by 1.0 cm in width with no depth was documented, with a pink peri-wound and well-defined edges. Per the assessment, treatment was to cleanse coccyx with NSS and apply Calazime (zinc oxide paste) ointment and cover with dry dressing three days a week. This was noted to be the first wound assessment with measurements and staging.Review of a weekly wound assessment, dated 01/18/26, revealed Resident #25 had a SDTI. This was documented as Wound #3. The assessment indicated the wound was on the resident's left buttocks and acquired (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 01/18/26. Measurements of 1.0 cm in length by 1.0 cm in width with no depth was documented, with a pink peri-wound. Per the assessment, treatment was to apply Calazime ointment and cover with a protective dressing. No cleansing treatment was noted. This was noted to be the first wound assessment with measurements and staging.Review of a weekly wound assessment, dated 01/19/26, revealed Resident #25 had a Stage II pressure ulcer on her right buttocks. This was documented as Wound #2. It indicated the wound was acquired on 01/18/26. The wound measured 2.0 cm in length by 2.0 cm in width and had no depth. The peri-wound was described as pink with well-defined edges. Treatment for this wound was to be cleansed with NSS, applying Calazime and dry dressing three days a week. This was noted to be the first wound assessment with measurements and staging.Review of Resident #25's medical record revealed a History and Physical (H&P) dated 01/20/25. The H&P failed to identify or address the resident's skin condition. The H&P further failed to identify any need for prevention or treatment of pressure ulcers. On 1/20/26 at 11:38 A.M., an interview with Resident #25 revealed she had a facility acquired pressure ulcer. During interview she explained it burned and was very uncomfortable. She believed the staff was applying some cream and some padding to it. No pressure relieving mattress or other specialty mattress noted at that time.On 01/21/2026 from 9:15 to 11:15 A.M., Resident #25 was observed to be lying in bed. She was flat on her back with the head of the bed elevated. She was on a standard mattress. No intervention or attempts by staff to encourage her to turn on her side to relieve pressure to her coccyx and buttocks were made during the entire observation period. On 01/21/26 at 12:24 P.M., an interview with Licensed Practical Nurse (LPN) #211 revealed an admission note, dated 01/14/26, which indicated the resident had a boney prominence to sacrum which was reddened, but not open, and applied house zinc to the area. No wound care orders were noted on admission. The baseline care plan for Resident #25 did not contain interventions for wound care. LPN #211 revealed a second assessment was completed on 01/15/26 at 12:07 A.M. which indicated her coccyx was red and blanchable and the plan was to continue with barrier cream and to encourage the resident to turn and reposition; however, no orders were written, and there was no documented evidence the interventions were implemented. The skilled nursing charting dated 01/16/26, 01/17/26, 01/18/26, indicated the resident had no open areas on skin and there were no orders for wound care on the record until 01/19/26. She confirmed Resident #25 required care for a pressure ulcer which had developed since admission to the facility. LPN #211 indicated Braden scales were to be completed on residents upon admission.On 01/22/26 at 1:13 P.M., an interview with the DON confirmed Resident #25 did not have interventions in place, including a pressure relieving mattress, until after the ulcers had declined. The pressure relieving mattress was not implemented until 01/21/26. She reported wounds at the facility were addressed weekly by a wound care nurse, who would come to the facility every Monday. She verified the H&P dated 01/20/26 failed to identify or address the resident's skin condition. The H&P further failed to identify any need for prevention or treatment of pressure ulcers. Resident #25 had not been seen by the wound care nurse on the Monday after her wound was identified, and the staff had notified the wound care nurse on 01/22/26 of the need to see the resident.On 01/22/26 at 2:35 P.M., an observation of wound care for Resident #25 completed by LPN #202 revealed Resident #25 had three areas of skin concern. The resident had a Stage II pressure ulcer on both her right and left buttocks located in the gluteal cleft. There were no other open areas noted. The resident did have a light red, blanchable area on her coccyx. These observations were confirmed by LPN #202 at the time of observation.

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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. Based on observation, record review and interview, the facility failed to ensure orders were obtained for residents requiring oxygen administration. This affected two (Resident #5 and Resident #25) of three residents reviewed for oxygen use. The facility census was 16.Findings include:1. Review of the medical record for Resident #5 revealed an admission date of 11/20/23. Diagnoses included diverticulitis of intestine, asthma, muscle weakness, unsteadiness on feet, assistance with personal care, wedge compression fracture of the third vertebra; depression, parkinsonism, rheumatoid arthritis, and muscle wasting.Review of a Minimum Data Set (MDS) 3.0 assessment, dated 12/31/25, revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 15 on a 0-15 scale. A score of 15 would indicate the resident had intact cognitive function, or normal thinking and memory. The MDS also indicated the resident was dependent in all activities of daily living.Review of a care plan for Resident #5, dated 01/04/26, revealed a focus of care for oxygen therapy related to ineffective gas exchange. The goal was for no signs or symptoms of poor gas exchange and included an intervention of oxygen from one to four Liters (L) per minute per nasal cannula.On 01/20/2026 at 11:00 A.M., an observation revealed Resident #5 had oxygen via nasal cannula at a flow rate of 2.5 Liters (L). She reported she was to be on 3L of oxygen. The flow rate of 2.5L was confirmed by Licensed Practical Nurse (LPN) #211 on 01/20/26.Review of the current medication administration record for Resident #5 failed to reveal orders for oxygen administration or flow rate.On 01/20/26 at 11:10 A.M., an interview with LPN #211 confirmed Resident #5 had oxygen at 2.5L via nasal cannula. She reported the resident should have been on a flow rate of 3L. During the interview, the LPN #211 checked the orders for Resident #5's oxygen, and found the resident did not have any orders to be on oxygen.2. Review of the medical record for Resident #25 revealed an admission date of 01/14/26. Diagnoses included chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, pneumonia, essential hypertension, anxiety disorder and major depressive disorder. Review of the MDS 3.0 assessment, dated 01/15/26, revealed a BIMS score of 13 on a 0-15 scale, indicating Resident #25 had intact cognitive functioning, or normal thinking and memory. On 01/20/26 at 11:38 A.M., interview and observation of Resident #25 revealed she had been on oxygen for some time. She was noted to be on 1.5 L of oxygen per minute via nasal cannula. This was confirmed by LPN #211 at the time of the observation.Review of vital signs documentation for Resident 25 revealed oxygen levels taken daily from 01/14/26 through 01/21/26. The resident was wearing oxygen when the vital signs were taken on all days except 01/14/26 and 01/15/26.Review of medical record for Resident #25 revealed skilled nursing charting dated 01/16/26, 01/17/26, 01/18/26, which indicated the resident was wearing oxygen.Review of a care plan for Resident #25, dated 01/14/26, failed to reveal any evidence of oxygen care planning or interventions.Review of the medical record for Resident #25 failed to reveal any orders for oxygen use. This was confirmed by LPN #211 on 01/21/26 at 12:26 P.M.Review of a facility policy titled Oxygen Administration, dated 2010, revealed the facility would provide safe oxygen administration. The policy indicated the staff should verify there was a physician order for oxygen and review the resident care plan for any specific or special needs for the resident prior to applying oxygen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366187	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Minerva Rehabilitation and Nursing Center	1035 East Lincolnway Minerva, OH 44657

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, interviews and reviews of facility policies, the facility failed to follow proper infection control processes during incontinence care and blood glucose testing for Resident #3 and wound care for Resident #25. This affected two (Residents #25 and #3) of four residents reviewed for infection control. The facility census was 16.Findings include:1. Review of the medical record for Resident #25 revealed an admission date of 01/14/26. Diagnoses included chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, pneumonia, essential hypertension, anxiety disorder and major depressive disorder. Review of the Minimum Data Set (MDS) 3.0 assessment for Resident #25, dated 01/15/26, revealed a Brief Interview for Mental Status (BIMS) score of 13 on a 0-15 scale. A BIMS score of 13 indicated intact cognitive functioning, or normal thinking and memory. On 01/22/26 at 2:35 P.M., an observation of wound care for Resident #25 revealed Licensed Practical Nurse (LPN) #202 did not perform appropriate hand hygiene throughout the dressing change. LPN #202 performed hand hygiene, applied clean gloves, and then lowered the head of the bed, positioned resident, adjusted her clothing to reveal the dressing, then removed the soiled dressing without first performing hand hygiene and changing her gloves. She then cleansed the wound and applied the new dressing without performing hand hygiene or changing her gloves. On 01/22/26 at 3:00 P.M., an interview with LPN #202 confirmed she should have adjusted bed and resident clothing, then performed hand hygiene and donned gloves prior to performing wound care. She also acknowledged hand hygiene should have again been performed after removing the soiled dressing, and new gloves should have been applied prior to wound care being performed and new dressing being applied. Review of a facility policy titled Handwashing/Hand Hygiene, dated 2001, revealed the facility considered hand hygiene the primary means to prevent the spread of infection. The policy indicated personnel should use an alcohol-based hand rub containing at least 62% alcohol or soap and water after contact with a resident's intact skin, after handling used dressings, after contact with objects in the immediate vicinity of the resident, and after removing and disposing of personal protective equipment. Review of a facility policy titled Dressings, Dry/Clean, dated 2001, revealed guidelines for the application of dry, clean dressings. The policy provided the staff was to position the resident, including clothing to provide access to affected area, wash hands thoroughly, apply clean gloves, remove soiled dressing, discard gloves, wash hands thoroughly, open dressings and label with date, time and initials, then using clean technique open any other necessary products. The care provider should then wash hands, apply clean gloves, assess wound, and cleanse with ordered cleanser. Next apply the ordered dressing and secure. 2. Review of the medical record for Resident #3 revealed an admission date of 03/04/25. Diagnoses included chronic obstructive pulmonary disease, muscle wasting, unsteadiness, dysphagia, history of urinary tract infection, depression, metabolic encephalopathy, and malignant neoplasm of the prostate. Review of the MDS 3.0 assessment, dated 12/31/25, revealed Resident #3 has a BIMS score of 10 on (continued on next page)

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	366187	A. Building B. Wing	01/22/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a 0-15 scale. A BIMS score of 10 would indicate moderate problems with thinking and memory. The resident had a Foley catheter for urinary elimination. On 01/20/25 at 9:30 A.M., and observation of the entry to Resident #3 revealed signage indicating the resident was on Enhanced Barrier Precautions (EBP). The signage indicated staff was to don gowns and gloves when performing any personal care for a resident with an indwelling medical device. On 01/20/26 at 10:15 A.M., an observation of LPN #211 revealed she donned gloves only and performed bowel incontinence care for Resident #3. On 01/20/26 at 11:00 A.M., an interview with LPN #211 confirmed EBP signage was placed on doors for residents who have wounds, or any type of intravenous access or urinary catheters. She was aware Resident #3 was on EBP. She confirmed she did not wear a gown when providing incontinence care for Resident #3. Review of a facility policy titled Enhanced Barrier Precautions, dated 04/01/24, revealed the facility would follow state and federal guidelines to minimize the spread of Multidrug Resistant Organisms (MDROs) by implementing effective Personal Protective Equipment (PPE) usage. EBP was an infection control intervention designed to reduce transmission of resistant organisms which employed targeted gown and glove usage during high contact resident care activities. These activities included wounds and indwelling medical devices even when the resident did not have an identified infection. High contact care included dressing, bathing, transferring, providing hygiene, changing briefs or assisting with toileting, device care and any wound care. 3. An observation on 01/21/26 at 4:04 P.M. with LPN #202 of blood glucose testing for Resident #3 revealed the following: LPN #202 applied gloves, wiped down the top of the medication cart with a disinfectant wipe, placed paper towels on top of the medication cart, removed her gloves, and then immediately applied new gloves without hand hygiene being performed; LPN #202 then removed two glucometer's (devices that measure blood glucose (sugar)) from the medication cart, removed alcohol pads from the medication cart, removed a container of blood glucose test strips (a strip where blood is placed in a designated section and then inserted into a glucometer to measure blood glucose levels) from the medication cart, cleaned a glucometer with a disinfecting wipe, placed the glucometer on a paper towel, removed gloves, and then immediately applied new gloves without hand hygiene being performed; LPN #202 then cleaned the next glucometer, placed it on a paper towel, removed her gloves without hand hygiene being performed, picked up a glove from the ground and disposed of it into the trash, removed a finger stick lancet from the medication cart, entered Resident #3's room and explained the procedure, moved the bedside table near the resident, and then applied gloves; the rest of the blood glucose testing procedure was performed. An interview on 01/21/26 at 4:21 P.M. with LPN #202 verified hand hygiene was not performed after removing old gloves before new gloves were applied. LPN #202 verified Resident #3 was in EBP, and a gown was not worn during blood glucose testing a high contact care activity. Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses that included cellulitis (a skin infection) of the left lower limb, type II diabetes, coronary artery disease, and high blood pressures. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #3 required set up or moderate assistance for activities of daily living, did not reject care, and was (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cognitively intact. Review of Resident #3's current Treatment Administration Record (TAR) from 01/01/26 to 01/21/26 revealed the resident was in EBP related to wounds and a peripherally inserted central catheter (PICC) (an intravenous catheter that extends from a vein in the arm into the large vein just before the heart that is often used for long term antibiotic administration). Review of the facility policy titled Handwashing/Hand Hygiene, dated 08/2015, revealed hand hygiene is the primary method to prevent the spread of infections, all personal shall follow the handwashing/hand hygiene procedures, hand hygiene should be performed after removing gloves, and hand hygiene should be performed after entering isolation precaution settings. Review of the facility policy titled Enhanced Barrier Precautions (EBP) Policy and Procedure, dated 04/01/24, revealed Enhanced Barrier Precautions is used to minimize the spread of Multidrug Resistant Organisms (MRDO's) by effective Personal Protective Equipment (PPE) usage, gown and gloves are to be used during high contact resident care activities, EBP is indicated anytime a resident has wounds or indwelling medical devices such as a PICC line, and a high contact activity included care where there is a skin opening.