STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366197	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardens at St Henry The	522 Western Avenue Saint Henry, OH 45883

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interview and facility policy review, the facility failed to maintain a safe sanitary kitchen. This had the possibly to affect 23 out 25 residents who receive food from the kitchen. The facility identified Resident #1 and #2 did not receive food from the kitchen. The facility census was 25. Findings Include: Observation of the kitchen on 09/02/25 at 9:48 A.M. revealed the trash can by the food serving table had a flip lid. The here was observed multiple areas of thick food particles on the can. Observation of the kitchen freezer revealed the door handles had a red sticky substance on them as did the surface of the refrigerator behind the door handles. These findings were verified with Dietary Manager #106 at the time of the observation. Facility policy Cleanliness, undated, revealed purpose to keep the kitchen and servery as clean as possible during and after operations.

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observation and interview the facility failed to properly place a catheter bag. This affected one (#33) of one residents in the facility with a catheter. Census was 25. Records Reviews for Resident #33 revealed resident was admitted on [DATE] with diagnosis fracture of shaft of humerus and left arm, major depressive disorder, anxiety, and panic disorder.The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #33 was cognitively intact and was admitted with suprapubic catheter due to neuromuscular dysfunction of bladder. Observation of Resident #33 on 09/02/25 at 10:38 A.M. revealed suprapubic catheter bag laying on the floor folded in half beside Resident #33's bed.Interview with RN #101 verified suprapubic catheter bag was laying on the floor beside the bed.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and policy review the facility failed to provide care for peripherally inserted central catheter. This directly affected one resident, #12, of one reviewed for intravenous catheters. The facility census was 25.Findings Include:Review of the medical record of Resident #12 revealed an admission date of 03/18/25. Diagnoses include urinary tract infection and Extended-Spectrum Beta-Lactamase in urine. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #12 to be cognitively intact. The assessment indicated no intravenous catheter. Review of the physician order dated 08/25/25 revealed an order to change the midline dressing every week. The order indicated this should occur on Mondays. Interview and direct observation of Resident #12 on 09/02/25 at 8:45 A.M. revealed a peripherally inserted central catheter (PICC) in the right upper arm. The dressing was loose and dated 08/25/25. Direct observation and interview on 09/02/25 at 9:00 A.M. with Registered Nurse (RN) #110 provided verification the dressing was loose and overdue to be changed. Review of the policy titled Midline Dressing Changes, dated 01/17/19, revealed the midline catheter dressings will be changed every five to seven days.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interview, and policy review the facility failed to ensure medications were securely stored. This had the potential to affect two residents, (#18 and #19), identified by the facility as being confused and independently mobile residents. The facility census was 25. Findings Include:Observation on 09/02/25 at 8:50 A.M. an antibiotic was noted on the medication cart which was located in the hallway. The cart was unattended. Registered Nurse (RN) #110 was observed to exited a resident room and verified the medication had been lying on the medication cart unattended. The medication was labeled Resident #12 and contained Ertapenem sodium (antibiotic) solution reconstituted 1 gram. Review of the policy titled Medication Storage, undated, revealed medications will be stored in a manner that ensures the safety of the residents. All medications will be stored in a locked cabinet, cart, or medication room that is accessible only to authorized personnel.

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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 observation, medical record review, staff interview, and policy review the facility failed to follow infection control procedures for residents in isolation. This directly affected one resident, (#12), and had the potential to affect five residents, #01, #02, #12, #16, and #33, on isolation. The facility census was 25.Findings Include:Review of the medical record of Resident #12 revealed an admission date of 03/18/25. Diagnoses include urinary tract infection and Extended-Spectrum Beta-Lactamase in urine. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #12 to be cognitively intact. The assessment indicated no isolation. Review of the physician order dated 08/26/25 revealed an order for contact isolation. Observation on 09/02/25 at 8:45 A.M. revealed a sign on the door to Resident #12's room indicating enhanced barrier precautions. Personal protective equipment was available for use. Observation on 09/02/25 at 9:00 A.M. revealed Registered Nurse (RN) #110 entered the room of Resident #12 along with this surveyor. RN #12 did not don gloves nor gown and proceeded to touch the midline catheter dressing on Resident #12's right upper arm, without gloves. RN #110 exited the room and returned with gloves and a disposable isolation gown. RN #110 donned the items and proceeded to initiate the administration of an antibiotic intravenously. Observation on 09/02/25 at 1:00 P.M. revealed the signage at the entrance to Resident #12's room had been changed to indicate contact isolation in place of the enhanced barrier precautions. Interview on 09/02/25 at 2:00 P.M. with RN #110 provided verification the signage had been changed to the increased restrictive isolation, and it should have been contact isolation for a while now. Review of the policy titled Enhanced Barrier Precautions undated revealed gloves and gowns are to be worn with high contact with residents.