

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

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                           |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>366233                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY<br>COMPLETED<br><br>12/24/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Morris Nursing Home                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>322 South Charity Street<br>Bethel, OH 45106 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                           |                                                 |
| F 0880<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Many                        | <p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record review, observation, staff interviews, and facility Enhanced Barrier Precautions (EBP) signage, the facility failed to initiate enhanced barrier precautions as required. This affected one resident (#22) of two residents reviewed for EBP. The facility also failed to ensure the separation of clean and dirty linen. This had the potential to affect all residents in the facility. The facility census was 14. Findings include: 1. Review of the medical record revealed Resident #22 was admitted to the facility on [DATE] with diagnoses of orthopedic aftercare for right below the knee amputation, indwelling urinary catheter for neurogenic bladder, hypertension, severe sepsis, and alcohol dependence. Review of the Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #22 had intact cognition and was always continent of bowel and had an indwelling catheter in place for the bladder. Review of physician orders for Resident #22 revealed an order dated 12/17/25 for an indwelling urinary catheter due to neurogenic bladder. The catheter was to be changed monthly and as needed and catheter care was to be performed every shift. There was no physician order for EBP. Review of the plan of care for Resident #22 dated 12/17/25 revealed nothing about an indwelling foley catheter or EBP. Observation on 12/22/25 at 9:35 A.M., during initial tour of the facility, revealed Certified Nursing Assistant (CNA) #55 and CNA #56 had just completed direct care to Resident #22 and used only gloves as personal protective equipment. It was also revealed Resident #22 had no signage indicating EBP was in place and there was no personal protective equipment (PPE) available for staff use. Interviews on 12/22/25 at 9:40 A.M. with CNA #55 and CNA #56 revealed no knowledge Resident #22 was to be on EBP. Interview on 12/22/25 at 9:44 A.M. with Registered Nurse (RN) #16 verified Resident #22 had an indwelling urinary catheter and had not been placed on EBP since admission on [DATE]. RN #16 also verified there was no physician order for EBP, no EBP signage in place, and no PPE available for staff use. Review of the facility EBP signage revealed everyone must clean their hands, including before entering and when leaving the room, and that providers and staff must also wear gloves and a gown for the following high-contact resident care activities designated as dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, and device care or use that includes central lines, urinary catheter, feeding tube, tracheostomy, and wound care of any skin opening requiring a dressing. 2. Observation on 12/22/25 at 10:30 A.M. of the laundry area revealed a room approximately twelve (12) feet by twelve (12) feet with only one entrance/exit. Located inside the designated laundry area were two residential-style hot water tanks to the right of the door. To the left was the clean linen cart and a table to fold clean linens. Past this area on the right was a plastic bin (with no cover) used to transport dirty linen, which had to be brought into the room past the clean linen cart and the folding table. The commercial washer and dryer sat on the far wall of the room. The door to the washing machine was located almost directly opposite the door to the dryer with a separation of approximately two (2) feet. A make-shift line for hanging clean personal clothing on hangers was by the dryer and the clean clothing from this line would have to pass the dirty linen bin. There was no barrier separating the dirty linen from the clean linen. There was also no PPE available for staff to utilize when handling dirty linen. Interview on 12/24/25 at 9:30 A.M. with CNA #38 and CNA #40 (continued on next page)</p> |                                                                                           |                                                 |

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<br>REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|--------------------------------------------------------------------------|-------|-----------|

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

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                           |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>366233                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY<br>COMPLETED<br><br>12/24/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Morris Nursing Home                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>322 South Charity Street<br>Bethel, OH 45106 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                           |                                                 |
| F 0880<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Many                        | revealed CNAs are responsible for washing and drying facility linen and resident personal linen. CNA #38 and CNA #40 verified there was no barrier in the laundry room to separate dirty linen from clean linen and the clean linen was stored in the laundry room. They also stated there was no PPE was available when handling dirty linen. 12/24/2025 11:04 AM Interview with the Administrator and Interim DON verified there was no barrier in the laundry room that separated the dirty and clean linen. The DON revealed the barrier that separated the dirty linen from the clean linen was the plastic laundry bin used for dirty linen. Review of the facility policy titled Proper Handling and Storage of Linens, undated, revealed all linen is handled, stored, transported, and processed in a manner that will prevent contamination and maintain a clean environment for residents, staff, and visitors. Clean linens are stored in an area separate from the storage of any soiled linens. |                                                                                           |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                           |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>366233                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                      | (X3) DATE SURVEY<br>COMPLETED<br><br>12/24/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Morris Nursing Home                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>322 South Charity Street<br>Bethel, OH 45106 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                           |                                                 |
| <p>F 0657</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, interview, and policy review, the facility failed to ensure resident care conferences occur quarterly with the Interdisciplinary Team and included the resident and/or resident representative. This affected seven residents (#1, #3, #4, #10, #12, #13, #16) out of seven residents reviewed for care conferences. The facility census was 14. Findings include:</p> <p>1. Record review for Resident #16 revealed this resident was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease, dementia, and benign prostatic hyperplasia.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed this resident had severe cognitive impairment, required assistance with activities of daily living and was always incontinent of bowel and bladder.</p> <p>Record review for Resident #16 revealed the only care conference held in 2025 was in October.</p> <p>2. Record review for Resident #3 revealed this resident was admitted to the facility on [DATE] with the following diagnoses: Bipolar Disorder, Chronic Respiratory Failure with Hypoxia, and Type 2 Diabetes</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed this resident had moderate cognitive impairment, required supervision and assistance with activities of daily living, and was always incontinent of bowel and bladder.</p> <p>Record review for Resident #3 revealed the only care conference held in 2025 was in October.</p> <p>Review of the facility policy titled Care Plans, Comprehensive Person-Centered, dated on March 2022, revealed the resident has the right to participate in their treatment, and the facility provides advanced notice of care planning.</p> <p>3. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE]. Diagnoses included cerebral ischemia, major depressive disorder, unspecified psychosis, hypertension, dementia, and auditory hallucinations.</p> <p>Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #1 had severe cognitively impaired. Resident #1 required supervision with eating, was dependent with toileting, dependent with bathing, and dependent with personal hygiene.</p> <p>Review of Resident #1 care conferences held revealed there was no evidence of a care conference sign in sheet to demonstrate a meeting with the Interdisciplinary Team (IDT) or with the resident and/or their representative.</p> <p>Interview on 12/22/25 at 3:45 P.M with the Administrator confirmed care conference sign in sheets were not completed for Residents #1.</p> <p>4. Review of the medical record revealed Resident #13 was admitted on [DATE]. Diagnoses included dysphagia oral phase, Alzheimer's disease with late onset, dementia, depression, hypertension, and (continued on next page)</p> |                                                                                           |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                           |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>366233                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY<br>COMPLETED<br><br>12/24/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Morris Nursing Home                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>322 South Charity Street<br>Bethel, OH 45106 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                           |                                                 |
| <p>F 0657</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>unspecified atrial flutter.</p> <p>Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE], revealed Resident #13 had severe cognitive impairment, was dependent with self-care, supervision for eating, dependent for toileting, dependent for bathing, and dependent for upper and lower body dressing.</p> <p>Review of Resident #13 care conferences held revealed there was no evidence of a care conference sign in sheet to demonstrate a meeting with the Interdisciplinary Team (IDT) or with the resident and/or their representative.</p> <p>Interview on 12/22/25 at 3:45 P.M with the Administrator confirmed care conference sign in sheets were not completed for Residents #13.</p> <p>5.Resident #10 was admitted to the facility on [DATE]. Diagnoses included rhabdomyolysis, schizoaffective disorder, and chronic kidney disease. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition.</p> <p>Review of Resident #10's medical record revealed Multidisciplinary Care Conferences dated 3/18/2025, 4/6/2025, 8/6/2025, and 11/12/2025. However, there was no evidence of a care conference sign in sheet to demonstrate a meeting with the Interdisciplinary Team (IDT) or with the resident and/or their representative.</p> <p>6.Resident #12 was admitted to the facility on [DATE]. Diagnoses included type II diabetes mellitus, cerebral Infarction, erythema multiforme, morbid obesity, and hemiplegia and hemiparesis. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition.</p> <p>Review of Resident #12's medical record revealed Multidisciplinary Care Conferences dated 2/11/2025, 4/14/2025, 8/4/2025, and 11/14/2025. However, there was no evidence of a care conference sign in sheet to demonstrate a meeting with the Interdisciplinary Team (IDT) or with the resident and/or their representative.</p> <p>7. Review of the medical record revealed Resident #4 was admitted to the facility on [DATE] with diagnoses of syncope and collapse, history of transient ischemic attack (TIA), diabetes mellitus type II, protein-calorie malnutrition and hypertension.</p> <p>Review of the Minimum Data Set (MDS) Annual assessment dated [DATE] revealed Resident #4 had severe cognitive impairment, was always incontinent of bowel and frequently incontinent of bladder. The resident was dependent for eating, oral and personal hygiene, toileting, bathing, dressing, bed mobility and transfer.</p> <p>Review of the medical record for Resident #4 revealed no documentation Resident #4 or Resident #4's representative participated in the development of the plan of care or that the facility conducted quarterly care conferences for the first quarter of 2025, second quarter of 2025, or third quarter of 2025.</p> <p>Interview on 12/22/25 at 3:45 P.M with the Administrator confirmed care conference sign in sheets were not completed for Resident #1, Resident #3, Resident #4, Resident #10 Resident #12, Resident #13, and Resident #16.</p> |                                                                                           |                                                 |

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

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                           |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>366233                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY<br>COMPLETED<br><br>12/24/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Morris Nursing Home                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>322 South Charity Street<br>Bethel, OH 45106 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                           |                                                 |
| F 0730<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Some                        | Observe each nurse aide's job performance and give regular training.<br><br>Based on record review and staff interviews, the facility failed to ensure a performance review for every nurse aide was conducted at least once every twelve months. This affected four (Certified Nurse Aide (CNA) #33, CNA #38, CNA #25, and CNA #40) out of six nurse aides reviewed. The facility census was 14. Findings Include: Record Review of employee files on 12/23/25 at 3:00 P.M revealed CNA #33, CNA #38, CNA #25, and CNA #40 did not have an annual performance evaluation. Interview on 12/24/25 at 8:30 A.M with the Administrator confirmed CNA #33, CNA #38, CNA #25, and CNA #40 did not have an annual performance evaluation. |                                                                                           |                                                 |

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

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                           |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>366233                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY<br>COMPLETED<br><br>12/24/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Morris Nursing Home                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>322 South Charity Street<br>Bethel, OH 45106 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                           |                                                 |
| F 0947<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Some                        | <p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>Based on record review and staff interviews, the facility failed to ensure Nurse aides had at least 12 hours of annual continuing education for four (Certified Nurse Aide (CNA) #33, CNA #38, CNA #25, and CNA #40) out of six nurse aides reviewed. The facility census was 14. Findings Include: Record Review on 12/23/25 at 3:05 P.M revealed CNA #37, CNA #33, CNA #25, CNA #40, and CNA #23 did not have 12 hours of annual continuing education. Interview on 12/24/25 at 8:35 A.M with the Administrator confirmed CNA #37, CNA #33, CNA #25, CNA #40, and CNA #23 did not have 12 hours of annual continuing education.</p> |                                                                                           |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                           |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>366233                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY<br>COMPLETED<br><br>12/24/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Morris Nursing Home                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>322 South Charity Street<br>Bethel, OH 45106 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                           |                                                 |
| F 0550<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record review, observation, staff interview, and review facility policy, the facility failed to promote dignity while dining. This affected two (#1 and #13) of two residents reviewed for dignity. The facility census was 14. Findings include: Review of the medical record revealed Resident #1 was admitted to the facility on [DATE]. Diagnoses included cerebral ischemia, major depressive disorder, unspecified psychosis, dementia, and auditory hallucinations. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #1 was severe cognitively impaired and required supervision with eating. Review of the medical record revealed Resident #13 was admitted on [DATE]. Diagnoses included dysphagia oral phase, Alzheimer's disease with late onset, dementia, and depression. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #13 had severe cognitive impairment and required supervision for eating. Observations on 12/23/2025 at 12:27 P.M. revealed Resident #1 and Resident #13 in the dining area getting ready to eat lunch. Certified Nursing Assistant (CNA) #55 and CNA #40 were observed applying clothing protectors to Resident #1 and Resident #13. These clothing protectors were designed to hook behind the residents' necks. Interview on 12/23/25 at 12:30 P.M. with CNA #40 confirmed the clothing protectors are used to prevent the food from getting on residents' clothes. CNA #40 stated it is easier to get the food off of the clothing protector than the residents' clothes after they get done eating. Review of the policy titled Community Information and Policies, including Resident Rights revealed the residents rights were to be treated at all times with courtesy, respect, and full recognition of dignity and individuality.</p> |                                                                                           |                                                 |

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

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                           |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>366233                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                      | (X3) DATE SURVEY<br>COMPLETED<br><br>12/24/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Morris Nursing Home                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>322 South Charity Street<br>Bethel, OH 45106 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                           |                                                 |
| F 0582<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record review, staff interview, review of Notice of Medicare Non-Coverage (NOMNC) letters, and policy review, the facility failed to ensure proper notice was provided to the resident and/or resident representative when the facility was discontinuing Medicare services. This affected one resident (#23) of three residents reviewed for Beneficiary Notification. The facility census was 14. Findings include: Review of the medical record revealed Resident #23 was admitted to the facility on [DATE] with diagnoses of cerebral infarction with left (non-dominant) side hemiplegia and hemiparesis, acute and chronic respiratory failure with hypoxia, aphasia, dysphagia, diabetes mellitus type II, hypertension and atrial fibrillation. Review of the Minimum Data Set (MDS) Significant Change of Status assessment dated [DATE] revealed Resident #23 had severe cognitive impairment, required supervision for eating, maximal assistance for oral and personal hygiene, toileting, bathing and dressing, and was dependent for bed mobility and transfers. Review of the facility generated NOMNC for Resident #23, which downloaded to the electronic medical record in the miscellaneous tab, revealed the last covered day of Medicare Part A services was dated as 06/18/25 and was signed and dated by Resident #23's representative on 06/18/25. The NOMNC for Resident #23 the facility provided to the surveyor had a visibly altered date of having been signed by Resident #23's representative on 06/16/25. Interview on 12/23/25 at 1:15 P.M. with the Interim Director of Nursing and Business Office Manager #57 verified Resident #23's NONMC was signed by Resident #23's representative on 06/18/25. The Interim Director of Nursing and Business Office Manager #47 verified the altered date on the copy of Resident #23's NOMNC provided by the facility. Review of the facility policy titled Medicare Advance Beneficiary and Medicare Non-Coverage Notices, revised September 2022, revealed residents are informed in advance when changes will occur to their bills. If the resident's Medicare covered Part A stay or when all of Part B therapies are ending, a Notice of Medicare Non-Coverage (NOMNC) is issued to the resident at least two calendar days before benefits end.</p> |                                                                                           |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                           |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>366233                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY<br>COMPLETED<br><br>12/24/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Morris Nursing Home                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>322 South Charity Street<br>Bethel, OH 45106 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                           |                                                 |
| F 0610<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | Respond appropriately to all alleged violations.<br><br><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record review, review of facility self-reported incident and investigation, staff interview and facility policy review, the facility failed to thoroughly investigate an alleged violation. This affected one (#3) of one resident reviewed for abuse. The facility census was 14. Findings include:Record review for Resident #3 revealed an admission to the facility on [DATE]. Diagnoses included bipolar disorder, chronic respiratory failure with hypoxia, and type two diabetes. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 had moderate cognitive impairment. Review of the self-reported incident dated 11/12/25 revealed Resident #3 reported physical abuse by a staff member. Review of the investigation revealed no documentation of assessing any like residents in the facility for abuse from a staff member.Interview on 12/24/25 at 9:10 A.M. with the Administrator confirmed no additional residents were assessed for the investigation.Review of the facility policy titled Abuse and Neglect Policy, dated November 2018, revealed under the area of Investigation revealed the facility will investigate all allegations of abuse. The investigation will include interviews with residents with first hand knowledge of the incident and written statements from residents with first hand knowledge of the incident. |                                                                                           |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                           |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>366233                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY<br>COMPLETED<br><br>12/24/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Morris Nursing Home                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>322 South Charity Street<br>Bethel, OH 45106 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                           |                                                 |
| F 0628<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | Provide the required documentation or notification related to the resident's needs, appeal rights, or<br>bed-hold policies.<br><br><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on<br>interview, record review, and review of facility policy, the facility failed to notify the Ombudsman of a<br>transfer to the hospital and failed to provide the bed hold policy to the resident representative in<br>writing. This affected one (#19) of three residents reviewed for transfers. The facility census was 14.<br>Findings include: Review of the medical record revealed Resident #19 was admitted to the facility on<br>[DATE]. Diagnoses included chronic obstructive pulmonary disease with acute exacerbation,<br>dysphagia, transient ischemic attack, generalized anxiety disorder. Review of the most recent<br>Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the Resident #19 had intact<br>cognition. Review of Resident #19 progress note dated 10/09/25 revealed resident left facility at<br>approximately 11:30 PM via stretcher. There was no evidence the resident or resident representative<br>was provided the bed hold policy in writing or the Ombudsman was notified of the transfer. Interview<br>on 12/23/25 at 10:32 A.M. with the Administrator confirmed the Ombudsman was not notified of the<br>transfer of Resident #19 to the hospital. Interview on 12/23/25 at 10:46 A.M. with the Administrator<br>confirmed no bed hold notice or written notice was provided to Resident #19 or Resident #19<br>representative when transferred out of the facility. Review of the policy titled Transfer or Discharge<br>Facility Initiated, dated 10/2022, read notice of transfer or discharge, notice of transfer is provided to<br>the resident and representative as soon as practicable, notice of facility bed hold policies are<br>provided to the resident and representative within 24 hours of emergency transfer, the facility will<br>send a copy of the discharge notice to a representative of the Office of the State LTC Ombudsman,<br>notice to the Office of the State LTC Ombudsman will occur at the same time the notice of discharge<br>is provided to the resident and resident representative. |                                                                                           |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                           |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>366233                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY<br>COMPLETED<br><br>12/24/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Morris Nursing Home                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>322 South Charity Street<br>Bethel, OH 45106 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                           |                                                 |
| F 0760<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from significant medication errors. This affected one resident (#12) out of five residents who received insulin. The facility census was 14. Findings include: Review of the medical record revealed Resident #12 was admitted to the facility on [DATE] with diagnoses including type II diabetes mellitus, cerebral Infarction, and morbid obesity. Review of the medication orders revealed Insulin Degludec FlexTouch Subcutaneous Solution Pen-injector 100 UNIT/milliliter (ML), inject 80 units subcutaneously every morning and at bedtime. Review of the December 2025 Medication Administration Record (MAR) for Resident #12 revealed on 12/05/2025, 12/07/2025, 12/11/2025, 12/12/2025, 12/17/2025, and 12/22/2025 the morning dose of Insulin was not documented as being administered. Interview on 12/23/2025 at 1:05 P.M. with the Interim Director of Nursing (DON) confirmed the morning scheduled doses of insulin were not documented as being administered on 12/05/2025, 12/07/2025, 12/11/2025, 12/12/2025, 12/17/2025, and 12/22/2025. The Interim DON stated It looks like it wasn't given, I would say it wasn't given because there is no documentation. Review of facility policy titled Medication Handling and Administration Rules, dated 2025, revealed all medication administrations must be recorded in the resident's Medication Administration Record (MAR). Any medication errors, including missed doses or incorrect administration, must be reported immediately. |                                                                                           |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                           |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>366233                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY<br>COMPLETED<br><br>12/24/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Morris Nursing Home                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>322 South Charity Street<br>Bethel, OH 45106 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                           |                                                 |
| F 0761<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>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.</p> <p>Based on observation, interview, review of the resident medication list, and policy review, the facility failed to ensure all medications were stored and labeled properly. This had the potential to affected two (#3 and #10) out of 14 residents with medications stored in a medication cart. The facility census was 14. Findings Include: Observation on 12/24/25 at 2:35 P.M with Registered Nurse (RN) #14 revealed in medication cart #1 there were 20 famotidine pills with an expiration date of November 2025. Also, in the medication cart #1 there was one bottle of bisacodyl with an expiration date of July 2025. Interview on 12/24/25 at 2:40 P.M with RN #14 confirmed in medication cart #1 there were 20 famotidine pills with an expiration date of November 2025 and one bottle of bisacodyl with an expiration date of July 2025. Review of the facility medication list by order revealed Resident #3 and Resident #10 had orders for bisacodyl and Resident #3 had orders for famotidine. Review of the facility policy titled Medication Handling and Administration Rules revealed medication must have an expiration date and follow Ohio state regulations and federal guidelines.</p> |                                                                                           |                                                 |