

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366250	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/02/2026
NAME OF PROVIDER OR SUPPLIER Kimes Nursing and Rehab LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 75 Kimes Lane Athens, OH 45701	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, and policy review, the facility failed to ensure a resident, who was at risk for falls and had a history of falls, had their fall prevention interventions implemented as per their plan of care and failed to ensure facility staff who are knowledgeable of resident transfers attended an appointment with a resident. This affected two residents (#21, #44) of two residents reviewed for falls. Findings include: 1 .Record review revealed Resident #21 was admitted to the facility on [DATE] with diagnoses including pericardial effusion and cardiac tamponade. Review of an MDS assessment dated [DATE] revealed Resident #21 had severely impaired cognition, had no behaviors, was dependent on staff for toileting hygiene, was dependent on staff for transfers, and was frequently incontinent of bowel and bladder. Review of a care plan dated 04/21/26 revealed Resident #21 was at risk for falls related to difficulty in walking and weakness. Goals were to minimize risk of falls and fall related injuries through the review. Interventions included but were not limited to call light in reach; keep commonly used items in reach; therapy evaluations as ordered; and wear appropriate footwear when ambulating or mobilizing in the wheelchair. Review of a care plan dated 04/21/26 revealed Resident #21 required assistance with activities of daily living (ADLs) related to weakness and difficulty in walking. Goals included improving ADL abilities and continue to have needs met on a daily basis through the review date. Interventions included but were not limited to total assistant for toileting transfers and total assistance for transfers. Review of an order dated 04/24/26 revealed Resident #21 had an eye doctor appointment scheduled for 05/27/26 at 1:45 P.M. with the facility to transport. Review of a provider note dated 05/27/26 by Provider #260 revealed Resident #21's exam was unable to be completed. Resident #21 who was wheelchair bound and hard of understanding did not have an aide/caretaker with her even though she lived in a nursing home. Resident #21 was very anxious and mentioned she did not know why she had an appointment and she wanted to go home. Resident #21's hands and feet were shaking throughout her time at the appointment. Resident #21 also had to use the bathroom and was unable to do so on her own so the office staff assisted her to, during, and from the bathroom. The nursing home she lives at was notified and were instructed to reschedule the appointment when someone could accompany Resident #21. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/28/26 at 9:03 A.M. with Maintenance Director (MD) #154 revealed he is the supervisor for the facility transport. MD #154 stated there was not an aide that would go on local appointments, just the driver. MD #154 stated once the driver had to travel further for appointments, they would request an aide for safety and social reasons. MD #154 stated he was not familiar with Resident #21 but from what he knew did not feel she would be able to go to an appointment alone and wouldn't feel comfortable taking her to an appointment alone in case she needed something. MD #154 stated he did not think an aide went with Resident #21 to her appointment and the driver was not an aide and would not have been able to transfer Resident #21 to the toilet or back to her wheelchair. MD #154 stated the facility driver was not available due to medical issues. Interview on 05/28/26 at 9:12 A.M. with Eye Doctor Receptionist (EDR) #261 revealed Resident #21 attended her appointment on 05/27/26 with a driver from the facility. Resident #21 was basically nonverbal, was wheelchair bound, and while in the exam room repeatedly stated she needed to have a bowel movement and stated now, now. EDR #261 stated she assisted Resident #21 to the restroom and asked if it was alright if she helped to which Resident #21 nodded her head yes at each step. EDR #261 stated Resident #21 was completely dead weight and had to be lifted onto the toilet, she had a large bowel movement, then was unable to clean herself so EDR assisted with that as well. EDR #261 stated after getting Resident #21 in the wheelchair and back to the exam room, she did speak with the facility driver to make them aware of the situation. EDR #261 stated she does not know why the facility would send someone who is nonverbal and unable to move herself without an aide. EDR #261 confirmed she did not have any credentials or training to assist someone to and from the toilet, she was gentle and did the best she could. Interview on 05/28/26 at 9:19 A.M. with Eye Doctor Technician (EDT) #262 revealed she took Resident #21 from the lobby back to the exam room, Resident #21 was pretty much nonverbal but was able to answer a couple questions. EDT #262 stated she did not have much involvement in the situation. Interview on 05/28/26 at 10 A.M. with EDT #263 revealed Resident #21 came to her appointment with just a driver with her from the facility. EDT #262 took her back to the exam room, and EDR #261 assisted Resident #21 to the toilet. EDT #262 stated after using the bathroom, Resident #21's pants weren't on quite right so she assisted EDR #261 to pull up Resident #21's pants. EDT #263 stated EDR #261 lifted the resident while she pulled up resident's pants. EDT #263 stated Resident #21 did not know why she was at the appointment. When the facility was notified there wasn't an aide with her, they stated there should have been an aide with her. Interview on 05/28/26 at 10:15 A.M. with the director of nursing (DON) revealed the floor staff decide who goes on appointments with residents. The DON stated she was unsure why they didn't send anyone with Resident #21. The DON stated Resident #21 required transfer with a mechanical lift and someone should have gone with her. Interview on 05/28/26 at 12:40 P.M. with Provider #260 revealed she asked her staff if anyone had accompanied Resident #21 to assist with communication and was told no. Provider #260 stated once Resident #21 got out of the bathroom, she began asking questions and the resident was not able to answer them. Resident #21 stated she wanted to go home and appeared afraid. Provider #260 stated Resident #21's hands and feet were shaking which could be medically related but since the packet that was sent to the appointment was drenched in coffee and not readable, she was unable to determine that. Provider #260 stated she was not going to pressure Resident #21 into the examination and requested the driver take her back to the facility. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an undated policy titled Transportation, Diagnostic Services revealed if it is necessary the facility provide transportation, the social worker with be responsible to make arrangements through the business office. A member of the nursing staff or social services should accompany the resident to the appointment if family is not available. 2. Review of Resident #44's medical record revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included unspecified dementia with mood disturbance, anxiety disorder, hypertension, muscle weakness, abnormalities of gait and mobility, lack of coordination, and need for assistance with personal care. Review of Resident #44's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and her cognition was moderately impaired. She had a functional limitation in her range of motion (ROM) noted to her bilateral upper and lower extremities and used a wheelchair as a mobility device. She required partial/ moderate assistance with bed mobility and was a substantial/ maximum assist for transfers. Ambulation did not occur. She was coded on the MDS assessment as having fallen twice since her last assessment, with one without injury and the other with injury that was not major. Review of Resident #44's active care plans revealed she had a care plan in place for being at risk for falls and fall related injuries related to her diagnoses, impaired safety awareness, impaired decision making, gait/balance impairments, delirium, cognitive impairment, incontinence, impaired mobility, weakness, psychotropic drug use, history of falls, requiring the use of an assistive device, and requiring assistance with mobility/transfers. The goals were for the resident not to experience significant injury from a fall, maintain her highest level of independence with mobility while maintaining safety, and reducing fall occurrences and the possibility of injury through staff intervention. The interventions included the use of Dycem (a tacky material placed in the seat of a chair to prevent sliding) to her recliner to prevent sliding out. That intervention was added on 03/24/26. She also had an intervention for the staff to encourage appropriate footwear when out of bed, added on 03/17/26. On 05/20/26 at 10:09 A.M., an observation of Resident #44 noted her to be up in her tilt-space (reclining) wheelchair in the TV/ lounge area near the nurse's station. Registered Nurse (RN) #123 was asked to assist the surveyor with checking to see if the resident had Dycem under her, while sitting up in a wheelchair. RN #123 obtained the assistance of an aide that was working on the resident's hall. They assisted the resident back to her room and had her stand to see if Dycem was in the seat of her wheelchair as per her plan of care. There was no Dycem found on the seat of the wheelchair on top of the cushion the resident was sitting on. The cushion was custom to the wheelchair and was secured to the seat of the wheelchair with Velcro. Dycem should have been on top of the cushion only to prevent the resident from sliding out, but wasn't. The two employees searched the resident's room and did not find any Dycem in the resident's room. RN #123 stated she would have to get the resident some Dycem so they could apply it to her seat under the resident as per her plan of care. On 05/20/26 at 1:25 P.M., a second observation was made of Resident #44 where the resident was up in her wheelchair again in the TV/ lounge area across from the nurses' station. The resident was noted to be wearing socks that did not appear to be non-skid socks. She had been observed earlier that day wearing house slippers with a non-skid sole that was not on her feet when the second observation was made. RN #123 was asked to verify if the resident was wearing non-skid socks. The nurse checked the soles of the resident's feet and confirmed the socks the resident was wearing was (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	just regular socks. She acknowledged the resident's fall risk care plan indicated the resident would be encouraged to have appropriate footwear on at all times when out of bed. She went back to the resident's room and retrieved her slippers the resident was wearing earlier. She assisted the resident with putting them on and the resident thanked the nurse for bringing her shoes and did not give the nurse any trouble when putting them on. Review of the facility's policy on Managing Falls and Fall Risk (not dated) revealed the staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The staff, with the input of the attending physician's, would identify appropriate interventions to reduce the risk of falls. In conjunction with the attending physician, staff would identify and implement relevant interventions to try to minimize serious consequences of falling. This deficiency represents non-compliance investigated under Master Complaint Number 3025739.		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on record review, review of billing information, review of the facility assessment, review of the Administrator and Director of Nursing (DON) job descriptions, and interviews, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently. This affected 56 of 56 residents residing in the facility. The facility census was 56. Findings include: 1. The annual recertification and complaint survey was initiated on 05/17/26. Review of an undated governing body and facility organizational chart revealed the governing body consisted of: two owners, a holding company which is wholly owned by the facility owners, then the administrator who oversees department heads. Review of a tax bill prepared on 01/30/26 revealed property taxes would be due on 03/06/26 for the first half of the year, totaling \$21,451.50. Review of a statement dated 05/14/26 from Gas provider revealed the facility owed \$1,011.39 which needed to be paid immediately otherwise, shut-off was scheduled for 06/01/26. Additionally, \$672.88 was due on 05/29/26. Review of an invoice dated 05/23/26 from a bakery vendor revealed the facility owed \$1975.03 dating back to 01/12/26. Review of a receipt dated 05/26/26 revealed the Gas provider had been paid \$1684.27. Review of an email from the owning company Senior Controller (SC) #201 dated 05/26/26 at 9:00 A.M. revealed for some vendors, the facility was carrying some invoices beyond terms which was not unusual for the industry. SC #201 stated they were in contact with vendors and have payment arrangements in place and there was no risk of service interruption for resident care. Interview on 05/26/26 at 11:53 A.M. with the Administrator confirmed the facility received a shut-off notice for gas. The Administrator verified it wasn't until today (05/26/26) that the overdue bill was paid. Review of an online payment receipt from the local Treasurer's office dated 05/26/26 at 12:35 P.M. revealed a payment of property taxes was paid for \$23,597.15. Interview on 05/26/26 at 12:58 P.M. with a bakery vendor revealed the facility had not made a payment since March (2026) which was to pay some debt from 2025 and currently owe from 02/09/26 to current date. The bakery vendor stated the terms for payment are to be within 30 days but on average the facility doesn't pay until 82 days overdue. The bakery vendor stated the facility owed \$1975.03. Review of an email from bakery vendor dated 05/26/26 at 1:10 P.M. revealed the facility needed to pay \$1599.94 so their account would not be placed on cash on delivery (COD) status. The payment would be due by 06/01/26. Interview on 05/27/26 at 8:30 A.M. with Senior Controller (SC) #201 revealed property taxes were late being paid because they had a previous business office in Columbus so the bills were sent to the previous address instead of the current address. SC #201 stated once asked for evidence property taxes were paid, she realized what had happened and paid them. SC #201 stated with the bakery vendor, they were within terms of payment and a payment was made on 05/26/26. She stated they had never been notified they would be cash on delivery if they did not pay their bill. Regarding the gas, SC #201 stated you have to go into a portal to pull the invoice and her assistant accounts payable forgot to pull the bill until survey team requested evidence of payment. She confirmed that should not happen and it won't happen again in the future. Interview on 05/27/26 at 11:04 A.M. with Director of Nursing (DON) and Administrator revealed the QA committee meets monthly. During quarterly meetings, they identify trends and go over information for the minimum data set (MDS) including falls, wounds, behaviors, pharmacy, weights, infections, rehab, and activities of daily living management. The Administrator stated trends that had been previously identified were falls, showers, grievance reporting, medication errors, infection control, and training requirements. When a trend is identified, they then create a performance improvement plan (PIP), find the root cause, and establish a timeframe for improvement. The Administrator stated there were no current PIPs in place. At this time, they had not identified current concerns for change in condition, notification to the physician, ADLs, staff training and evaluations, infection control, financial solvency, or documentation. The Administrator and DON stated they did not feel like QAPI was effective yet and there were concerns prior to them starting QAPI that no one else had done it because staff would look at them like a deer (continued on next page)		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	in headlights when they run the meetings. The Administrator stated it is a work in progress at this time. The Administrator stated prior to the evening of 05/26/26, he did not have access to the facility's policy and procedure manual to know how to operate the facility per the company's policies. Review of a policy titled Quality Assessment and Assurance Plan dated 12/2009 revealed the program is in place and designed to monitor and evaluate the quality of resident care, pursue methods to improve care quality, and resolve identified problems. Review of a policy titled Governing Body dated 06/13/26 revealed the governing body is legally responsible for the conduct of the facility. The governing body shall appoint a licensed nursing home administrator who is responsible for the day-to-day management of the facility who ensures the facility complies with all federal, state, and local laws and regulations governing the operation of a skilled nursing facility. 2. Review of the personnel file for Activity Assistant #153 revealed a hire date of 01/29/25. There was no evidence the facility had checked the State nurse aide registry to check for any findings of abuse for Activity Assistant #153 upon hire. Interview with Human Resources staff #163 on 05/27/26 at 7:45 A.M. confirmed the State nurse aide registry had not been checked for findings of abuse for Activity Assistant #153 upon hire. Interview with Human Resources staff #163 on 05/27/26 at 9:15 A.M. revealed she had just started as the Human Resource staff in November 2025. Review of an Employee Dates Report revealed 30 employees had been hired since November 2025 who were not nurses or nursing assistants (Physical Therapy Assistants #141 and #144, Administrator #214 and #158, Hospitality aide #129, Housekeepers #219, #205, #206, #208, #172, #215, #102, and #116, Receptionist #207 and #117, Dietary Aides #156, #209, #178, #135, #187, #217, and #218, Cooks #114, #210, #211, #107, #212, #213, and #160, and Dietary Manager #142. Interview with Human Resources staff #163 on 05/26/26 at 3:30 P.M. revealed the facility had not checked the State nurse aide registry for findings of abuse for any staff except nurse aides and nurses, including the 30 listed above. She stated she was not aware that they needed to check for employees who were not nursing assistants or nurses. 3. Review of the personnel file for Registered Nurse (RN) #123 revealed a hire date of 11/14/25. Review of a Confirmation of State Residency form revealed RN #123 documented that she had not resided in the state for the previous five years. The form stated if the person had not resided in the state for the previous five years, they were giving consent to the facility to obtain a set of fingerprint impressions for criminal records check of the state, as well as providing a separate set of fingerprint impressions for the FBI. RN #123 had signed the form on 11/12/25. There was no evidence that an FBI background check had been completed for RN #123 (to check for crimes in other states that would disqualify the employee from working at the facility). Interview with Human Resources staff #163 on 05/27/26 at 7:45 A.M. confirmed there was no evidence an FBI background check had been completed for RN #123. She confirmed the FBI background check was required for RN #123. Review of the facility assessment (dated 02/23/26) revealed the assessment would be shared with the quality assurance performance improvement (QAPI) committee at a to be determined (TBD) date. There was no evidence that the facility assessment had been shared with the QAPI committee at the time of the annual survey that initiated on 05/17/26. In addition, the facility assessment identified the facility was licensed for 61 beds with a daily average census of 55-59 residents. Per the facility assessment policies and procedures were to be evaluated with each regulatory update and with new technologies being introduced to the facility staff. Review of a job description for Administrator revealed it was the primary purpose of his job to direct day-to-day functions of the facility in accordance with federal, state, and local standards, guidelines, and regulations to assure the highest degree of quality of care can be provided to residents at all times. Administrative functions included: review policies and procedures at least annually and make changes as necessary to assure continued compliance; ensure appropriate facility policies and procedures are followed when conducting background checks and when providing information to the Nurse Aide Registry; prepare an annual operating budget for approval by the governing body and allocate the resources to carry out programs and activities of the facility; assist in the establishment and maintenance of an adequate accounting system that reflects (continued on next page)		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the operating cost of the facility; review and interpret the monthly financial statements and provide information to the governing body; and ensure adequate financial records and cost reports are submitted to authorized government agencies as required by current regulations. Review of a job description for the DON revealed the primary purpose of her position was to plan, organize, develop and direct overall operation of our nursing service department in accordance with current federal, state, and local standards, guidelines, and regulations. Functions include make daily rounds of nursing service department to ensure all nursing service personnel are performing their work assignments in accordance with acceptable nursing standards; perform background checks on nursing service personnel in accordance with established procedures; ensure all CNA's are verified through the State Nurse Aide Registry; review nursing notes to ensure they are informative and descriptive of the nursing care being provided, they reflect the resident's response to the care, and such care is provided in accordance with the resident's wishes; schedule daily rounds to observe residents and determine if nursing needs are being met in accordance with the resident's request. This deficiency represents non-compliance investigated under Complaint Number 3003957.		