

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

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, observation, review of hospital records, and review of information from the National Library for Medicine, the facility failed to ensure residents with acute respiratory changes and decline in condition received comprehensive assessment and treatment in a timely manner. This affected two residents (#1, #21) of two residents reviewed for change in condition. The facility census was 56. Actual Harm occurred to Resident #21 on 05/04/26 when the resident was experiencing shortness of breath, had labored breathing, with oxygen levels desaturating into the 70's and 80's around 1:00 A.M. and Licensed Practical Nurse (LPN) #181 failed to complete a comprehensive assessment including checking vitals and lung sounds and failed to provide treatment to the resident. On 05/04/26 at 6:00 A.M. upon the arrival of dayshift, LPN #164, an immediate assessment was completed and Resident #21 was transferred to the hospital, where she was admitted with a diagnosis of bilateral pulmonary embolisms and remained in the hospital for nine days receiving treatment. Actual Harm occurred to Resident #1 on 02/17/26 when the resident, who had recently been diagnosed with COVID and pneumonia, had a significant change in condition and decline in respiratory status with continued low oxygen saturations without interventions and timely treatment in place until 02/28/26. The facility also failed to provide the resident's medical provider with abnormal lab results thereby not providing the resident's physician with the comprehensive condition of the resident which failed to provide the resident's physician with all the statistics to provide appropriate treatment to the resident. On 02/28/26 Resident #1 was sent to the hospital and admitted with diagnoses of multifocal pneumonia, acute on chronic hypoxic respiratory failure, and acute on chronic symptomatic anemia. The resident remained in the hospital for five days receiving treatment. Additionally, not rising to the level of harm, the facility failed to ensure resident skin impairments were identified and treated timely and failed to apply compression stockings used in the treatment of peripheral edema. This affected four residents (#2, #9, #15, and #28) of four residents reviewed for general skin concerns. The facility census was 56. Findings include: 1. Record review revealed Resident #21 was admitted to the facility on [DATE] with diagnoses including other pericardial effusion and cardiac tamponade. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #21's memory was severely impaired, had no behaviors, and did not have oxygen or a bipap (a bilevel positive airway pressure which is a noninvasive ventilator to help you breathe)/cpap (continuous positive airway pressure). Review of a care plan dated 04/22/26 revealed Resident #21 had altered respiratory status/difficulty (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 0684 Level of Harm - Actual harm Residents Affected - Few	this was the entire investigation. The DON stated she started the investigation because she knew the survey team would be looking into the concerns with Resident #21. The DON confirmed the nightshift nurse (LPN #181) did not complete any kind of assessment or progress note for Resident #21 during her shift (05/03/26-05/04/26). Review of a statement dated 05/19/26 by LPN #181 revealed she worked from 05/03/26 to 05/04/26 and when giving report to the dayshift nurse (LPN #164) had advised her to check Resident #21's oxygen saturations as the resident had a few times her oxygen dropped. The lowest number reported was 85% at which time a certified nursing assistant (CNA) and LPN #181 talked to Resident #21 who agreed to wear her c-pap mask to breathe better. After applying the c-pap and waiting approximately 15 minutes, Resident #21's saturations were reassessed and had increased to 93%. LPN #181's statement said she did not report anything in the 70's and if the saturations had remained in the 80's, she would have sent Resident #21 for emergency treatment. Interview on 05/20/26 at 1:30 P.M. with Physician #195 revealed he did not recall being notified of anything regarding Resident #21 on 05/04/26 nightshift. He stated he would want to be notified of oxygen saturations in the 70's and provide a full assessment of all vital signs and lung sounds. Interview on 05/20/26 at 2:30 P.M. with Registered Nurse (RN) #168 revealed she is the respiratory nurse for the facility and completes chest PT, box breathing, and incentive spirometers with residents, but does not work on the rehab side of the building. RN #168 stated if a resident oxygen desaturates into the 70's, it is an emergency and all nurses should be in the room preparing the resident to be sent out because there is a potential for the resident to code. Interview on 05/20/26 at 6:05 P.M. with CNA #132 revealed Resident #21 was having low oxygen saturations due to not wanting to wear her c-pap or oxygen during the night (05/03/26-05/04/26). CNA #132 stated Resident #21's oxygen saturation did read in the 70's at one point, but she would move the pulse oximeter to a different finger and get different readings in the 80's. CNA #132 could not remember an exact time the incident occurred but stated she retrieved LPN #181 who worked with her to convince Resident #21 to apply her c-pap. CNA #132 stated that once the c-pap was applied the oxygen saturation improved but was still fluctuating. CNA #132 stated the resident appeared to be breathing faster than normal. Review of an article titled Acute Pulmonary Embolism on the National Library of Medicine website (https://www.ncbi.nlm.nih.gov/books/NBK560551/) revealed pulmonary embolism (PE) leads to impaired gas exchange due to obstruction of the pulmonary vascular bed leading to a mismatch in the ventilation-to-perfusion ratio because alveolar remains the same. A timely diagnosis of PE is crucial because of the high associated mortality and morbidity which may be prevented with early treatment. 30% of untreated patients with Pes die while on 8% die after timely therapy. Diagnosing a PE can be difficult due to the variety of nonspecific clinical signs and symptoms in patients with acute PE. The most common symptoms include dyspnea, pleuritic chest pain, cough, hemoptysis, presyncope, and syncope. Dyspnea may be acute and severe in a central PE. In patients with pre-existing conditions including heart failure or pulmonary disease, worsening dyspnea may be the only symptom. 2. Record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of oxygen saturation on 02/16/26 at 11:59 P.M. revealed Resident's oxygen was at 80% with oxygen in place via nasal cannula. There was no evidence that the resident's medical provider was notified of the change in the resident's condition. Review of a nursing note dated 02/17/26 at 5:13 A.M. by RN #225 revealed Resident #1's oxygen was in the low 70's this shift. RN #225 was teaching the resident to breathe in his nose and out his mouth. Resident #1 stated he could hardly take a deep breath. There was no evidence that the resident's medical provider was notified of the resident's change in condition. There was no additional information in the note that included a comprehensive respiratory assessment. Review of a nursing note dated 02/17/26 at 10:58 A.M. by the DON revealed Resident #1's oxygen saturation was at 80% which exceeded a low of 90%. The respiratory nurse was notified to evaluate Resident #1 on possible use of incentive spirometer. There was no evidence that the resident's medical provider was notified of the resident's decline in condition. Review of a nursing note dated 02/17/26 at 3:17 P.M. by RN #168 revealed per nursing report at 6:00 A.M., Resident #1's oxygen dropped to 80%, oxygen was increased to six lpm via nasal cannula and oxygen saturation increased to 90%. Upon assessment at 6:30 A.M., oxygen saturation was 89-90% on six lpm via nasal cannula. Lungs had scattered rhonchi and a nonproductive cough. Inhalers were administered per orders, and as needed nebulizer treatment was administered this shift. Resident was assessed and treated by the respiratory therapist. A call was received by infectious disease provider stating resident's hemoglobin was 6.3 and wanted to make sure Physician #195 was aware and treating. An urgent message was left for Physician #195 at 11:00 A.M.,(specific to the low hemoglobin) and the facility was awaiting a response. There was no evidence the medical provider was notified of the resident's declining respiratory status. Review of orders revealed Resident #1 had an order in place dated 02/17/26 for oxygen six lpm via nasal cannula continuously every shift. Review of a lab note dated 02/17/26 at 3:45 P.M. by RN #189 revealed Resident #1's lab tests which were drawn on 02/16/26 were abnormal including a critically low hemoglobin of 6.3 (normal 13.5-17.5), red blood count of 2.37 (normal 4.25-5.65), platelet count of 115, sed rate of 34 (normal less than 15), sodium of 132 (normal 136-145), albumin of 2.5 (normal 3.4-5.4), calcium of 8.3 (normal 8.5-10.2), CK of 32 (normal 22-198), blood urea nitrogen (BUN) of 42.1 (normal 6-24), creatinine of 1.72 (normal 0.7-1.3), and glucose of 230. Physician #195 was made aware and gave new orders for further lab work to be drawn tomorrow (02/18/26). There was no evidence the resident's physician was notified of the resident's decline in respiratory status and condition. There was no evidence Resident #1's lab tests ordered for 02/18/26 were completed or results received. Review of a nursing note dated 02/23/26 at 1:33 P.M. by DON revealed Resident #1 received a critical low lab result for hemoglobin of 6.7. (This specific lab result was called directly to the facility from the lab; no other lab results were provided at this time). Physician #195 was notified and stated he would be in shortly to review and had no new orders at this time.(Please note- subsequent interview (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	transitioned to Daptomycin due to renal function; he was started on Azithromycin (antibiotic) and Levofloxacin (antibiotic) for multifocal pneumonia. The Azithromycin finished on 03/04/26 and the Levofloxacin was dosed every 48 hours due to renal function with the last dose scheduled for 03/09/26. Discharge medications included Daptomycin 50 mg/milliliters (ml) injection infuse 12 ml (600mg total) into a venous catheter daily for seven days and Levofloxacin 750 mg tablet take one tablet by mouth every other day for four days. Interview on 05/20/26 at 1:09 P.M. with Physician #195 revealed he should be notified at any time oxygen saturation is in the 70's and staff should document any rechecks of oxygen levels. Physician #195 did not recall being notified of Resident #1's oxygen dropping into the 70's or staff increasing oxygen to six lpm. Physician #195 stated they should notify him of that, not necessarily before due to it being emergency, but he should be made aware as soon as possible. Physician #195 stated he was not made aware of respiratory struggles with Resident #1 and if he had known about that in conjunction with the low hemoglobin, which he was aware of, he would likely have requested Resident #1 to be sent to the emergency department due to possible need of blood transfusion. Physician #195 stated he ordered iron levels and other labs on 02/17/26 to evaluate the cause of low hemoglobin and he does not know what happened to those lab results. Physician #195 stated he needs to know the results to try and figure out what is going on with Resident #1 to cause low hemoglobin. Interview on 05/20/26 at 2:30 P.M. with RN #168 revealed she is currently the respiratory nurse but was not in February (2026). RN #168 stated she does not give her own orders but will add recommendations in the online order system which have to be approved by a physician. RN #168 stated if a resident is having low oxygen saturation or other signs of respiratory distress on night shift, they should not wait for the respiratory nurse to arrive at the facility on dayshift because it is likely an emergency and should be an all hands-on deck. RN #168 stated if someone is oxygen saturated in the 70s, there is a chance a code could happen so the nursing staff should be working together to get the resident sent out to the hospital. RN #168 stated she could not recall notifying Physician #195 of Resident #1's oxygen desaturating on 02/17/26. RN #168 stated she documented what nightshift told her since they had not documented and then added on to her note what she did for the resident. RN #168 stated respiratory therapy did not actually see him as a patient but laid a second set of eyes on the resident to ensure there were no additional needs. Interview on 05/26/26 at 10:32 A.M. with the DON revealed when Resident #1 was desaturating to 80% on 02/17/26, she did not send him out or call the doctor because they tried to address concerns in-house first since he had COVID, pneumonia and low hemoglobin. The DON stated low hemoglobin can impact breathing. The DON stated she had not been aware of the nursing note prior to hers on 02/17/26 which stated Resident #1 was desaturating into the low 70's but stated she could not speak on behalf of the nurse for not calling the doctor. The DON stated at one point, Resident #1 was sent out to the emergency room for low hemoglobin but the hospital sent him right back without transfusing him. The DON stated she would attempt to locate the labs ordered on 02/18/26 along with occult stools. Review of the labs which were ordered on 02/18/26 revealed they were received by the facility on 05/26/26. The labs indicated Resident #1 had a low iron of 13 (normal 59-158), low TIBC of 141 (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	(normal 170-500), high retic of 2.01 (normal 0.5-2), low hematocrit of 21.8 (normal 40-52), low red blood cells of 2.58 (normal 4.4-5.9), and a critically low hemoglobin of 6.7 (normal 13.3-17.7). The critically low hemoglobin was called in to LPN #227. The occult stools were not provided upon request. Interview on 05/26/26 at 11:53 A.M. with the Administrator confirmed the labs which were ordered on 02/18/26 were not received or reviewed by the facility until 05/26/26 and the occult stools were not provided. Review of a policy titled Change in a Resident's Condition or Status dated 12/2016 revealed the facility shall promptly notify the resident, the provider, and representative of changes in resident's medical/mental condition and/or status. The nurse will notify the attending physician or on-call when there's been a need to alter resident's medical treatment significantly and need to transfer to the hospital/treatment center. A significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, impacts more than one area of the resident's health status, requires interdisciplinary review and/or revision to the care plan, and ultimately is based on the judgement of the clinical staff and the guidelines outline the Resident Assessment Instrument. Prior to notifying the provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider including information prompted by the communication form. Except in medical emergencies, notifications will be made timely when a change occurs in the resident's medical/mental condition or status. The nurse will record in the medical record information relative to changes in the resident's medical/mental condition or status. 3. Review of the record for Resident #2 revealed an admission date of 02/17/23 and diagnoses including chronic kidney disease, diabetes, hydronephrosis with renal and ureteral calculous obstruction, and chronic pain. Resident #2 had a physician's order dated 04/20/26 to cleanse a skin tear on the right thigh with wound wash and pat dry. Then apply collagen powder to the wound bed, cover with methylene blue foam, and then cover with a gauze island border dressing on Monday, Wednesday, and Friday. Review of wound physician progress notes revealed on 05/13/26 the resident had a skin tear of the right thigh measuring 0.4 by 0.4 by 0.2 centimeters. Observation of the treatment to the right thigh on 05/18/26 at 1:30 P.M. revealed LPN #119 apply collagen powder to the wound bed, then foam, then a gauze dressing. The resident was observed to have a 0.4 centimeter by 0.4-centimeter sheared area on the right thigh. LPN #119 did not cleanse the area before applying the collagen powder and dressings. Interview with LPN #119 on 05/18/26 at 1:50 P.M. confirmed the wound was to be cleansed with wound wash prior to applying the new dressing and he did not. There was no evidence in the record that the area had worsened or had any signs of infection. 4. Review of Resident #9's medical record revealed the resident was admitted to the facility on [DATE]. His diagnoses included malignant neoplasm (cancer) of the prostate, malignant neoplasm of the rectum, and anemia. Review of Resident #9's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and his cognition was moderately impaired. He had a functional limitation of his range of motion (ROM) in his upper and lower extremities bilaterally. He was dependent on staff for bed mobility and transfers. Review of Reside		

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on review of employee personnel files, staff interview, and policy review, the facility failed to conduct thorough background checks of employees upon hire to ensure there were no findings of abuse, neglect, exploitation, or misappropriation of property. The facility failed to check the State nurse aide registry for findings of abuse for 30 employees hired since November 2025, failed to conduct an FBI background check for one nurse who had not lived in the the state for the past five years, and failed to check information from previous and/or current employers (reference checks) for 90 of 90 employees hired since November 2025. This affected 56 of 56 residents residing in the facility. Findings include:1.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 (HR) 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. 2. 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 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. 3. Review of the personnel file for RN #123 revealed a hire date of 11/14/25. Review of the personnel file for Activity Aide #153 revealed a hire date of 01/29/25. There was no evidence that any attempts had been made to check information from previous and/or current employers prior to hiring the employees. Interview with Human Resources staff #163 on 05/26/26 at 3:30 P.M. revealed the facility does not do any reference checks on employees prior to 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 the facility had hired 90 employees since November 2025 (RN's #255, #103, #248 and #239, Director of Nursing #125, Administrators #158 and #214, MDS nurse #175, LPN's #224, #256, #241, #243, #119, #161, #245, #181, #247, #250, #257, #121, #105, #164, and #236, Physical Therapy Assistant's #144 and #141, Occupational Therapy Assistant #107, Respiratory Therapist #230, Nursing Assistants #249, #112, #220, #221, #223, #179, #242, #251, #252, #110, #253, #182, (continued on next page)		

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

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	#104, #220, #118, #133, #246, #226, #254, #155, #228, #233, #176, #131, #258, #165, #232, #259, #169, #108, #234, #152, #235, #237, #238, and #240, Housekeepers #219, #205, #206, #208, #172, #215, #116, and #102, Hospitality Aides #129, #140, #124, and #174, Receptionist #117 and #207, Dietary aides #187, #135, #156, #209, #178, and #217, Cooks #213, #160, #114, #210, #211, and #212, and Dietary Manager #142. Human Resources staff #163 confirmed on 05/26/26 at 3:30 P.M. that reference checks had not been completed for any of those employees. Review of the facility policy titled Abuse Prevention Program dated 2001 and revised December 2016 revealed our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. As part of the resident abuse prevention, the administration will: conduct employee background checks and will not knowingly employ or otherwise engage any individual who has: a. been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; b. have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property. The facility policy did not specifically address conducting reference checks with previous/current employers.		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of schedules, director of nursing job description, Staffing Data Report, facility assessment, and interviews, the facility failed to ensure they had Registered Nurse (RN) coverage daily for eight consecutive hours. This had the potential to affect 56 of 56 residents who resided in the facility. Findings include: Review of the Facility assessment dated [DATE] revealed staff members required for the care of residents included registered nurses (RN)s and licensed nursing staff. There should be three nurses for dayshift and two at night. Review of a staff schedule for 05/03/26 revealed the Director of Nursing (DON) worked from 2:00 P.M. to 6:00 P.M. and was the only RN scheduled to work for the day. Review of a Staffing Data Report dated 05/08/26 revealed for the first quarter of 2026, the facility had triggered excessively low weekend staff and one star staffing rating. Interview on 05/26/26 at 9:15 A.M. the DON confirmed there was not an RN for eight consecutive hours on 05/02/26. Review of the DON Job Description dated 01/08/26 revealed it is the responsibility of the DON to ensure a sufficient number of licensed practical and/or registered nurses for each tour of duty is assigned to ensure quality of care is maintained.		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on review of personnel files, review of the director of nursing job description, and interviews, the facility failed to ensure annual nurse aide performance reviews were completed. This had the potential to affect 56 of 56 residents in the facility. Findings include: Review of the personnel file for Certified Nursing Assistant (CNA) #125 revealed she was hired on 10/12/23. Further review of her file revealed she had not received an annual performance evaluation. Review of the personnel file for CNA #106 revealed she was hired on 04/10/15. Further review of her file revealed she had not received an annual performance evaluation. Review of the personnel file for CNA #203 revealed she was hired on 07/24/87. Further review of her file revealed she had not received an annual performance evaluation. Interview on 05/27/26 at 9:07 A.M. with Human Resources (HR) #163 confirmed CNA #106, #125, and #203 did not have annual evaluations completed on or within 30 days of their due dates. Review of a job description for the Director of Nursing (DON) revealed it was her responsibility to assist HR in developing performance evaluation schedules, criteria, and annual reviews for the nursing service department.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, the facility failed to maintain a clean/ sanitary environment in the dry storage room located in the facility's kitchen used for the storage of dry food goods. This had the potential to affect all residents residing in the facility. The facility's census was 56. Findings include: On 05/19/26 at 11:28 A.M., an observation of the kitchen while observing tray line for the lunch meal served noted cleanliness/ sanitation concerns in the dry food storage room. The dry food storage room was a separate room within the facility's main kitchen behind the food preparation and cooking area. The door to the dry food storage room was propped open despite it having a self-closing mechanism by use of a lanyard strap that was tied around the door knob on the outside of the door and to a metal shelf that was located in the dry food storage room behind the entry/ exit door to the dry food storage room. There was loose uncooked pasta noodles and a large uncooked and unpeeled potato that were found under a bottom rack of one of the metal storage shelves. There was also a rodent trap that was on the floor under that rack. Findings were verified by Dietary Manager #142. On 05/19/26 at 11:30 A.M., an interview with Dietary Manager #142 confirmed the door to the dry food storage room should not be propped open with it have a self-closing mechanism on it. She further confirmed leaving food products that had been dropped on the floor was not going to help any rodent problems that they may have as evidenced by the rodent trap in that same area. She removed the potato from the floor and was going to sweep under the shelf to clean up the uncooked pasta.		

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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 (continued on next page)		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 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 (continued on next page)		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 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.		

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	
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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on review of the facility assessment, policy and procedure, and interviews, the facility failed to maintain an adequate quality assurance and program improvement program. This affected 56 of 56 residents residing in the facility. The facility census was 56. Findings include: 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 recertification 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. 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, or documentation. The Administrator and DON stated they did not feel like QAPI was effective yet and they were concerns prior to them starting QAPI that no one else had done it because staff look at them like a deer in headlights when they run the meetings. The Administrator stated it is a work in progress at this time. 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.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, staff interview, policy review, and review of Legionella prevention maintenance records, the facility failed to implement their infection prevention and control program (standard precautions, enhanced barrier precautions and Legionella prevention) to prevent the spread of infection. This affected three residents (#2, #21, #57) of 27 residents reviewed for infection control concerns and had the potential to affect all 56 residents residing in the facility. Findings include: 1. Review of the record for Resident #57 revealed an admission date of 09/03/25 and diagnoses including diabetes, hypertension, and cerebral palsy. Resident #57 had deep tissue pressure ulcers to the left and right heels with a treatment order 05/06/26 to cleanse areas with wound wash, pat dry, apply betadine to wound and leave open to air every day. Observation of the treatment to the heels on 05/19/26 at 7:15 A.M. revealed Licensed Practical Nurse (LPN) #105 to place the treatment supplies, including bottle of wound cleanser, a package of gauze pads, a box of gloves, and a non-disposable tape measure on the resident's over bed table without any barrier. The overbed table was not cleaned first. LPN #105 did not wear a gown to complete the treatment to the heels. There was a sign on the door indicating Enhanced Barrier Precautions were to be followed by staff. (Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. Multidrug-resistant organisms (MDROs) refer to microorganisms, predominantly bacteria that are resistant to one or more classes of antimicrobial agents. Although the names of certain MDROs describe resistance to only one agent, these pathogens are frequently resistant to most available antimicrobial agents). LPN #105 applied gloves and used a non-disposable tape measure (with retractable coiled tape) to measure the wounds on the residents heels. She was observed to touch the heels with the tape measure. The left heel had a dark dry scab measuring 2.5 by 2.5 centimeters. The right heel had a dark dry scab measuring 5 by 4.5 centimeters. She cleansed the heels with wound cleanser spray then painted the areas with betadine swabs. LPN #105 then put the non-disposable tape measure in her pocket without cleaning it. She then put the bottle of wound cleanser and the package of gauze back into the treatment cart without cleansing after it had sat on the bedside table in the resident's room without any type of barrier. She set the box of gloves used in the treatment back on top of the treatment cart. LPN #105 then got the tape measure out of her pocket and laid it on top of the treatment cart without cleansing it first. Interview with LPN #105 on 05/19/26 at 7:35 A.M. confirmed Resident #57 was on EBP and she should have worn a gown to complete the treatment and she did not. She confirmed she did not use a barrier on the overbed to set the supplies on to prevent them from becoming contaminated. She stated she did not have a disposable measuring device available so she used the non-disposable tape measure. Interview with the Director of Nursing on 05/19/26 at 9:13 A.M. revealed Resident #57 should be on EBP (no physician's order for) and staff should wear a gown to provide treatments. She stated staff should set their treatment supplies on a barrier on the bedside table to prevent contamination. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Review of the record for Resident #2 revealed an admission date of 02/17/23 and diagnoses including hydronephrosis with renal and ureteral calculous obstruction, chronic kidney disease, diabetes, and chronic pain. Review of physician's orders revealed an order 06/30/25 to cleanse suprapubic catheter (a tube inserted directly into the urinary bladder through a small incision in the lower abdomen) site with normal saline, pat dry, cover with gauze dressing and secure with tape. There was a physician's order 09/04/25 for enhanced barrier precautions related to the suprapubic catheter. The resident also had a physician's order 04/20/26 for a treatment to a skin tear on the right thigh to include cleanse wound with wound wash, pat dry, apply collagen powder to wound bed, cover with methylene blue foam, and cover with gauze island border dressing. Observations on 05/18/26 at 11:15 A.M. revealed Resident #2 to be in bed. Urine was observed in a catheter bag on the side of the bed. Observation of the treatment to the right thigh on 05/18/26 at 1:30 P.M. included LPN #119 measuring the open area . The resident was observed to have a 0.4 centimeter by 0.4 centimeter sheared area on the right thigh. LPN #119 used a non-disposable tape measure (with retractable coiled tape) to measure the area. LPN #119 used an alcohol wipe to clean the tape measure after using it. He stated he was unable to find a disposable measuring tool to measure the wound with. Interview with the Director of Nursing on 05/18/26 at 3:30 P.M. revealed nurses should be using disposable measuring devices to measure wounds. She stated she would remove the non-disposable tape measure from the treatment cart. (However, a non-disposable tape measure was observed to be used for Resident #57 the next day). Observation of suprapubic catheter care for Resident #2 on 05/19/26 at 7:40 A.M. by LPN #105 revealed she dropped a multi pack of gauze sponges on the floor then picked them up and laid the package on top of the treatment cart (after it had touched the floor). LPN #105 applied gloves but did not put on a gown. A sign was observed on the door telling staff to follow EBP. (LPN #105 had just completed wound care for Resident #57 without wearing a gown for EBP). LPN #105 removed the soiled suprapubic catheter dressing, removed her gloves then, without washing her hands, applied clean gloves. She cleansed around the suprapubic catheter site with normal saline on gauze, applied a new dressing, removed her gloves, and washed her hands. Interview with LPN #105 on 05/19/26 at 7:50 A.M. confirmed she did not wear a gown to complete the treatment for Resident #2, who was on EBP. She confirmed she dropped the gauze on the floor then placed it on top of the treatment cart and she confirmed she did not wash her hands after removing soiled gloves and before applying clean gloves. Interview with the Director of Nursing on 05/19/26 at 9:25 A.M. confirmed staff are to wear a gown while performing a treatment for a resident on EBP. She confirmed staff should not place items on top of the treatment cart that have been dropped on the floor. She confirmed staff should wash their hands after removing gloves and before putting on clean gloves. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the undated facility policy titled Enhanced Barrier Precautions revealed the facility will implement EBP for residents identified with MDROs or residents with increased risk for transmission due to wounds or indwelling medical devices. to reduce transmission of MDROs while maintaining resident quality of life and participation in normal activities. The policy stated that staff will wear isolation gowns during high-contact resident care activities including wound care and device care. Review of the undated facility policy titled standard precautions revealed staff are to wash hands after removing gloves. It further stated to ensure that reusable equipment is not used for the care of another resident until it has been appropriately cleansed and reprocessed. Review of the undated facility policy titled Dressings, Dry/Clean revealed staff are to clean the bedside stand and establish a clean field. It further stated to clean the bedside stand after the dressing change. 3. Review of the facility undated Water Management Procedure revealed areas susceptible to Legionella Growth (Legionellosis refers to two clinically and epidemiologically distinct illnesses: Legionnaires' disease, which is typically characterized by fever, myalgia, cough, and clinical or radiographic pneumonia; and Pontiac fever, a milder illness without pneumonia (e.g., fever and muscle aches). Legionellosis is caused by Legionella bacteria) included incoming water supply; domestic hot water heater and storage tanks; all hot and cold water outlets, including sinks and showers, even if not in use; air conditioning and air handling units; circulating pumps; external hose bibs; tempering valves; ice machine; water fountain; and patient care machines including C-pap and Bi-pap machines and oxygen concentrators. Monitoring and control measures in the procedure included: cleanse and disinfect all hot and cold water outlets in use weekly, including vacant rooms and chiller to be serviced monthly by a contractor. It further included maintaining appropriate water temperature and quality by random water sampling. The procedure did not specify what random meant. Review of Legionella Precautionary Maintenance and Inspection Frequency records revealed hot and cold water outlets were being maintained monthly, instead of weekly per procedure. In addition, there was no evidence the chiller was being serviced monthly by a contractor. There was no evidence of any check of the water quality by random water sampling. Interview with Maintenance Director #154 on 05/17/26 at 2:00 P.M. revealed he did not know if the water at the facility had been sampled to test for Legionella. He stated he felt that he needed training on the procedures for preventing Legionella in the facility. Interview with the Administrator on 05/20/26 at 11:40 A.M. and 3:30 P.M. confirmed the water management plan included random checks of water quality. He stated he did not know if the water at the facility had been sampled to test for Legionella. He stated he did not know how often the random sampling was to be done. He confirmed the hot and cold water outlets were being maintained monthly and not weekly per procedure. He confirmed the procedure called for the chiller to be serviced monthly by a contractor and he did not know if this had been done. 4. Record review revealed Resident #21 was admitted to the facility on [DATE] with diagnoses including pericardial effusion and cardiac tamponade. Review of a care plan dated 04/22/26 revealed Resident #21 had altered respiratory status/difficulty breathing related to sleep apnea. The goal was for Resident #21 to have no complications related to (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	shortness of breath through the review date. Interventions included but were not limited to administer medication/puffers as ordered; CPAP setting 4/13 via full face mask; and nebulizer treatments as ordered. Review of orders revealed an order dated 05/06/26 for Resident #21 to have a CPAP/BIPAP in place at bedtime and nap times. Settings 4/13 and remove in the morning. Observation on 05/17/26 at 2:53 P.M. revealed Resident #21's CPAP was laying directly on her nightstand. Observation and interview on 05/20/26 at 8:42 A.M. with CNA #147 revealed Resident #21's CPAP mask was laying directly on the bedside table and not stored in a sanitary bag.		

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on review of personnel files and interviews, the facility failed to ensure facility staff received a minimum of 12 hours of in-services per year. This affected 56 of 56 residents living in the facility. Findings include: 1. Review of the personnel file for Certified Nursing Assistant (CNA) #125 revealed she was hired on 10/12/23. Further review of her file revealed no evidence she had received at least 12 hours of in-service education annually. 2. Review of the personnel file for CNA #151 revealed she was hired on 08/14/23. Further review of her file revealed no evidence she had received at least 12 hours of in-service education annually. 3. Review of the personnel file for CNA #132 revealed she was hired on 09/16/21. Further review of her file revealed no evidence she had received at least 12 hours of in-service education annually. Interview on 05/27/26 at 9:07 A.M. with Human Resources (HR) #163 confirmed CNA #125, #151, and #132 had no evidence they had completed at least 12 hours of in-services annually.		

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. Based on review of resident financial records, staff interview, and policy review, the facility failed to ensure residents had access to petty cash on an ongoing basis to include evenings and weekends. This could affect the seven residents whose personal funds were handled by the facility (#2, #6, #13, #25, #26, #27, and #43) of the seven residents reviewed for funds. The facility census was 56. Findings include: Review of resident personal funds records revealed the facility managed the personal funds for seven residents (Residents #2, #6, #13, #25, #26, #27, and #43). Interview with Business Office Manager #186 on 05/26/26 at 9:25 A.M. revealed residents, whose funds are handled by the facility, have access to petty cash at all times. She stated that business office staff are available Monday through Friday from 8:00 A.M. to 4:30 P.M. She stated that if a resident wanted money outside of those times, including weekends, there was a box behind the desk on the rehab unit that contained petty cash. She stated the rehab nurse had the key and would be able to get money out for the residents. Business Office Manager #186 further provided a paper that stated banking hours were from 8:30 A.M. to 4:30 P.M. Monday through Friday. It stated if you wish to request money from your personal funds held by the facility, please notify the rehab charge nurse. Interview with licensed practical nurse (LPN) #164, who was working as the rehab charge nurse on 05/26/26 at 10:30 A.M. (working 6:00 A.M. to 6:00 P.M.) revealed she was not aware of any petty cash box at the rehab desk. She stated she had not been trained on that and would not know how to get cash out for residents after hours when the business office was closed. Review of the facility undated policy titled Resident Trust Fund revealed after hours access to resident trust funds: In circumstances where a resident requires access to funds outside of normal business office or banking hours, the charge nurse on duty will be authorized to access the designated resident trust lock box containing limited petty cash funds.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and resident interview, the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team, to include the resident and resident representative and individuals who have knowledge of the resident and his/her needs, after each comprehensive and quarterly assessment. This affected four residents (#3, #5, #9, and #10) of 27 sampled residents reviewed for plans of care. The facility census was 56. Findings include: 1. Review of the record for Resident #3 revealed an admission date of 03/07/24 and diagnoses including End Stage Renal Disease with dialysis, diabetes, and hypertension. An annual Minimum Data Set (MDS) assessment completed 03/14/26 documented a brief interview for mental status score of 15, indicating intact cognition. Interview with Resident #3 on 05/17/26 at 1:32 P.M. revealed he had not participated in a care plan meeting in the last six months. He stated he would like to have one and in previous meetings his daughter was present. Record review revealed the last care conference summary was 12/07/25 and it indicated only the resident and social service person was present at the meeting, (no other interdisciplinary team members). It stated an invitation was mailed to his daughter with no response. Interview with Social Worker (SW)#130 on 05/19/26 at 10:15 A.M. revealed care conference meetings are to be held 48 hours after admission, quarterly, annually, with a significant change, upon readmission, or as requested. She stated the care conferences should coincide with the completion of MDS's. She stated in addition to the resident and resident representative, other disciplines should attend or participate including social services, therapy, nurse, and activities. She stated she had taken over social services at the end of February 2026. She confirmed there was no evidence of a care conference in March 2026 when the annual MDS was done. She stated there should have been a care conference in March 2026. She confirmed that the previous care conference in December 2025 included only social services and the resident. 2. Review of the record for Resident #10 revealed an admission date of 11/21/25 and diagnoses including tremors, migraines, Schwannomatosis (multiple benign tumors on nerves throughout the body), bipolar disorder, parkinsonism, schizoaffective disorder, and normal pressure hydrocephalus. Record review revealed MDS assessments completed 11/27/25 (admission), 01/16/26 (quarterly), and 04/18/25 (quarterly). A brief interview for mental status score was unable to be done on 04/18/26 and it was noted the resident had long and short term memory problems. Interview with Resident #10's brother on 05/17/26 at 5:09 P.M. revealed there had been no care conferences since admission. He stated he would like to participate in one as he would like to know what is being done to try to figure out what is causing the resident to decline in mobility. Record review revealed a care conference summary on 11/23/25 that stated a care conference was (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	held with the resident, passport, and family per phone (did not specify who). It indicated two staff were present (did not specify discipline). On 04/16/26 a care conference summary indicated a care conference was held with the resident and social services. It stated brother invited but chose not to participate. It did not indicate that any other interdisciplinary team members participated in the review of the care plan or care conference. Interview with SW #130 on 05/19/26 at 10:23 A.M. revealed she had called Resident #10's brother prior to the 04/16/26 care conference and left a voicemail. She stated he did not get back to her until after the meeting was held. She stated the other department heads did not go into the room for the conference but she did touch base with them prior. She confirmed the care conference summary did not indicate that any other team members participated in the review of the care plan or that the brother was given an opportunity for a care conference. 3.Record review revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, anemia, and depression. Review of an MDS dated [DATE] revealed Resident #5's cognition was intact. Review of a care conference dated 04/15/26 revealed the resident, her son, and Social Worker (SW) #130 were in attendance. No additional members of the interdisciplinary team were present. Interview on 05/17/26 at 2:57 P.M. with Resident #5 revealed she had not had a care conference yet. Interview on 05/18/26 at 4:51 P.M. with SW #130 revealed care conferences are completed within the first 48 hours of admission, quarterly, annually, as requested, or with significant changes. Attendees should include social worker, admissions, therapy, nursing, activities, and dietary. Interview on 05/26/26 at 8:23 A.M. with SW #130 revealed for Resident #5's care conference, her son did not get off work until five so she stayed late to meet with resident and her son. SW #130 stated the floor nurse who was working at the time was in attendance and she was not sure why she did not document that. SW #130 stated she went over as much information as she could and provided copies of the care plan and medication list. 4. Review of Resident #9's medical record revealed the resident was admitted to the facility on [DATE]. His diagnoses included malignant neoplasm of the prostate, malignant neoplasm of the rectum, and anemia. Review of Resident #9's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and his cognition was moderately impaired. He was not known to display any behaviors, nor was he known to reject care during the seven days of the assessment reference period. He had a functional limitation of his range of motion (ROM) in both his upper and lower extremities bilaterally. Review of Resident #9's active care plans revealed he had a care plan in place for being at risk for skin breakdown and infection related to his skin bruising easily and having thin, fragile skin. The (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs including drugs used without adequate indication for use. This affected four residents (#7, #22, #53, #72) of five residents reviewed for unnecessary medications. The facility census was 56.1. Review of the record for Resident #7 revealed an admission date of 01/13/26 and diagnoses including acute and chronic respiratory failure, hypertension, anxiety disorder, morbid obesity, and status post pneumonia. Record review revealed a physician's order 05/04/26 for Prednisone (a steroid medication) 40 milligrams in the morning for seven days for cold symptoms. Review of the medication administration record for May 2026 revealed the Prednisone 40 milligrams was given daily from 05/05/26 to 05/20/26 (16 days instead of 7). Interview with the Director of Nursing (DON) on 05/20/26 at 10:35 A.M. confirmed the Prednisone was ordered for seven days. She stated a stop date was not put into the computer system so the resident continued to receive the medication as of 05/20/26. She stated she called the physician and an order was given to taper the dose and discontinue the medication in five days. (Prednisone can not be stopped suddenly and must be tapered). 2. Review of the record for Resident #72 revealed an admission date of 04/07/26. Review of the facility infection surveillance report for April 2026 revealed Resident #72 had been taken to the hospital by his family for reports of ongoing weakness, agitation, and hallucinations with difficulty urinating. No other symptoms voiced. Diagnosed with urinary tract infection by the hospital and started on an antibiotic. Review of hospital records revealed he presented with increased falls, confusion, and concern for urinary tract infection (did not mention difficulty urinating). The assessment and plan stated: urinary tract infection with urinary incontinence. It stated a urine sensitivity was pending. On 04/06/26 it stated the urine was sensitive to the antibiotic Cipro. He was started on Cipro at the hospital on [DATE]. After admission to the facility on [DATE], the Cipro continued from 04/07/26 to 04/16/26 for a total of 18 doses. (the physician's order was for Cipro 500 milligrams twice daily for 9 more days). Review of the urine culture results from the hospital dated 04/06/26 revealed Resident #72 had 50,000-100,000 CFU/ml of Enterobacter cloacae. Review of nursing progress notes on 04/08/26 at 3:31 A.M. revealed the resident had no signs/symptoms of infection. Interview with Assistant Director of Nursing (ADON) #189 on 05/26/26 at 12:05 P.M. revealed the facility is supposed to complete an Infection Control Surveillance form for residents prescribed antibiotics to determine if the antibiotic is necessary. She confirmed the Infection Control (continued on next page)		

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	
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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveillance form was not complete for Resident #72. She confirmed that the Infection Surveillance form indicated that the criteria for a urinary tract infection included at least 100,000 CFU/ml of an organism and at least one of the following symptoms: acute dysuria or pain, swelling, or tenderness of testes, epididymis or prostate, fever or leukocytosis. She stated the results of urine culture and lack of symptoms were not discussed with the physician to determine if the resident should continue on the antibiotic after admission to the facility. Resident #72 was discharged home on [DATE]. 3. Review of the record for Resident #22 revealed an admission date of 05/03/26. Review of hospital records revealed the resident was admitted to the hospital 04/26/26 with chief complaint of confusion. Notes indicated the resident had urinary frequency and lower abdominal pain. Denied dysuria. Has had watery diarrhea for two weeks with abdominal cramping. Diagnosis of acute metabolic encephalopathy (a sudden disruption of brain function caused by a systemic illness, chemical imbalance, or organ failure) likely secondary to infection. Urine culture pending. Review of the urine culture results revealed 50,000 CFU/ml of Pseudomonas aeruginosa. Upon admission to the facility on [DATE], the resident had physician's orders for an antibiotic (Ceftriaxone sodium injection two grams daily by IV until 05/06/26. The resident received the medication on 05/04/26, 05/05/26, and 05/06/26). Review of nursing progress notes on 05/04/26 at 4:02 P.M. revealed the resident had no reports of urinary symptoms. Interview with Assistant Director of Nursing #189 on 05/26/26 at 12:05 P.M. revealed the facility is supposed to complete an Infection Control Surveillance form for residents prescribed antibiotics to determine if the antibiotic is necessary. She confirmed the Infection Control Surveillance form was not complete for Resident #22. She confirmed that the Infection Surveillance form indicated that the criteria for a urinary tract infection included at least 100,000 CFU/ml of an organism and at least one of the following symptoms: acute dysuria or pain, swelling, or tenderness of testes, epididymis or prostate, fever or leukocytosis. She stated the results of urine culture and lack of symptoms were not discussed with the physician to determine if the resident should continue on the antibiotic after admission to the facility. Record review revealed the resident was sent to hospital 05/14/26 with chest pain and did not return. 4. Record review revealed Resident #53 was admitted to the facility on [DATE] with diagnoses including radiculopathy, polyneuropathy, and rheumatoid arthritis. Review of a care plan dated 03/02/26 revealed Resident #53 was at risk for pain related to recent surgery, spinal stenosis, osteoarthritis, irritable bowel syndrome, gastro-esophageal reflux disease, and neuropathy. The goals included not having an interruption in normal activities due to pain through the review, will not have discomfort related to side effects related to analgesia through the review, and resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	through the review date. Interventions included but were not limited to administer analgesia per orders' evaluate effectiveness of pain interventions; monitor for probable cause of pain for each episode; monitor and document side effects of pain medications; monitor and record pain characteristics; administer treatments as ordered; administer medications as ordered; and encourage small frequent position changes. Review of a MDS dated [DATE] revealed Resident #53's cognition remained intact and resident had frequent pain of eight through the review period. Review of an order dated 04/07/26 revealed Resident #53 was receiving acetaminophen extra strength oral tablet 500 mg give two tablets by mouth every six hours as needed for pain. There were no parameters to specify which pain level to administer the acetaminophen. Review of an order dated 04/07/26 revealed Resident #53 was receiving oxycodone oral tablet 5 mg give one tablet by mouth every six hours as needed for pain. There were no parameters to specify which pain level to administer the oxycodone. Interview on 05/19/26 at 9:38 A.M. with the director of nursing (DON) confirmed there were no parameters in place for neither acetaminophen nor oxycodone to instruct staff on which pain medication to give based on the resident's pain level. Review of an undated policy titled Pain- Clinical Protocol revealed the physician and staff will identify resident's who have pain or are at risk for pain. The physician will order appropriate non-pharmacologic and medication interventions to address the individual's pain. Pain medications should be selected based on pertinent treatment guidelines.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, review of meal tickets, review of the facility's menu/ spreadsheet for specialty diets, review of diet orders, interview, and policy review, the facility failed to ensure all residents receiving a carbohydrate controlled diet (CCD) received the appropriate serving size of the dessert food item served during the lunch meal on 05/19/26. This affected two residents (Resident #58 and #65) and had the potential to affect 19 other residents (Resident #1, #3, #4, #5, #6, #13, #16, #21, #26, #27, #29, #31, #39, #40, #42, #50, #53, #56, and #57), who the facility identified as receiving a carbohydrate controlled diet. Findings include: On 05/19/26 at 11:10 A.M., an observation of the tray line for the lunch meal being served to the residents was completed to ensure diets were provided as ordered and appropriate serving sizes were served. The facility served regular diets, mechanically altered diets, pureed diets, CCD's, renal diets, and large portion diets. Two residents' meal tickets were observed during the tray line that identified those two residents (Resident #58 and #65) as being on a CCD. Dietary [NAME] #160 was noted to dip the main food items onto the plates that included pork loin, Malibu blend vegetables, and a baked potato. The plates were then handed to another dietary aide, who placed them on a tray and added the additional items that were to be served with the meal, which included wheat bread, sour cream and chives, margarine, and a lemon bar. The lemon bars were pre-packaged and all of the same size. Once the other food items were added on the tray, it was loaded into a food cart to be delivered to the residents. All residents were given a pre-packaged lemon bar for dessert. Two resident meal tickets were noted to come through that identified those two residents (Resident #58 and #65) to be on CCD. Both residents received a full serving of the pre-packaged lemon bar that had been removed from a large plastic bowl and placed onto the food cart being delivered to the location they were eating in. Review of the specialty menu and spreadsheet for the CCD's revealed the residents receiving that type of diet were to receive the same food items, as residents on a regular diet, but was to receive half a serving of the lemon bars. Findings were verified by Dietary Manager #142. On 05/19/26 at 11:17 A.M., Dietary Manager #142 confirmed those residents on a CCD were only to receive half a serving size of the pre-packaged lemon bars. She acknowledged two residents (Resident #58 and #65) had already been served a full serving of the lemon bar that all the other residents received. She removed the full serving of the lemon bar that was placed on Resident #65's tray with one that she had cut in half and re-packaged in plastic wrap. She then went to the unit where Resident #58's tray was delivered to and retrieved her lemon bar before she ate it replacing it with one of proper serving size. She then cut up enough of the full size lemon bars to be able to give the remaining residents on a CCD the proper serving size per the menu. She confirmed the residents on a CCD were only supposed to receive half the serving of the dessert being served on that day, as was clearly indicated on the specialty menu's spreadsheet. Review of the facility's policy on Therapeutic Diets revised December 2008 revealed therapeutic diets should be prescribed by the attending physician and the facility would strive for the fewest possible dietary restrictions. Diets modified for medical or nutritional needs would be considered therapeutic diets. Routine menus were planned by the Food Service Manager, and approved by a Registered Dietitian for nutritional adequacy. The regular menu would be modified by the Registered Dietitian for therapeutic diets, with input from the dietary manager for feasibility of kitchen production. The Food Service Manager would establish and use a tray identification system to ensure that each resident received his or her diet as ordered. Residents that were on therapeutic diets would not receive extra or reduced portions or modifications that were not part of the diet, unless approved by the attending physician in conjunction with the Clinical Dietitian.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, observations, and policy review, the facility failed to ensure documentation in the medical record was completed accurately to reflect residents' status. This affected four residents (#4, #5, #13, and #56) of 27 residents reviewed for accuracy of medical records. The facility census was 56. Findings include: 1. Record review revealed Resident #4 was admitted to the facility on [DATE] with diagnoses including multiple fractures of the ribs and muscle weakness. Review of a minimum data set (MDS) dated [DATE] revealed Resident #4's cognition remained intact, he had no behaviors, and he had skin tears. Review of a care plan dated 04/23/26 revealed Resident #4 was at risk for bruising related to bruising currently to bilateral upper extremities (BUE) and torso due to fall at home. The goal was for bruising to fade and disappear without any complications. Interventions included but were not limited to observe area and document any noted concerns, remind resident to alert staff if they notice any areas themselves, and weekly skin assessment. Review of a weekly skin assessment dated [DATE] revealed Resident #4 had bruises to BUE and torso. Review of a weekly skin assessment dated [DATE] revealed Resident #4 had bruises to BUE and right side. Review of a weekly skin assessment dated [DATE] revealed Resident #4 had no bruising. Review of a weekly skin assessment dated [DATE] revealed Resident #4 had no bruising. Review of a weekly skin assessment dated [DATE] revealed Resident #4 had no bruising. Observation and interview on 05/18/26 at 8:07 A.M. with Resident #4 revealed he had a large amount of bruising to BUE. Resident #4 stated staff were not monitoring the bruising. Observation and interview on 05/26/26 with Licensed Practical Nurse (LPN) #164 verified Resident #4 had bruising to BUE and stated the bruises had been there since admission with no changes. LPN #164 stated she was taught to only document on the bruising if there were changes. Interview on 05/26/26 at 10:42 A.M. with the Director of Nursing (DON) confirmed Resident #4 had bruising to BUE and weekly skin assessments completed on 05/06/26, 05/13/26, and 05/21/26 did not contain information about the bruising. The DON confirmed information regarding location of bruising should be contained in the assessments even if the bruising was not new. The DON verified Resident #4's assessments were inaccurate. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.Record review revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease and anemia. Review of a care plan dated 04/08/26 revealed Resident #5 had potential for impairment to skin integrity. The goal was to maintain or develop clean and intact skin by the review date. Interventions included but were no limited to educate resident of causative factors and measures to prevent skin injury; encourage good nutrition and hydration in order to promote healthier skin; and follow facility protocols for treatment of injury. Review of a skin assessment dated [DATE] revealed Resident #5 had bruises to BUE, left forehead, and eye. Review of a skin assessment dated [DATE] revealed Resident #5 had bruises to her face, right antecubital, left antecubital, right hand and left hand. Review of an MDS completed on 04/13/26 revealed Resident #5's cognition remained intact, she had no behaviors, and she had burns to her skin. Review of a skin assessment completed on 04/15/26 revealed Resident #5 had bruising to BUE and left side of forehead/eye. Review of a skin assessment dated [DATE] revealed Resident #5 had bruising to BUE. Review of a skin assessment dated [DATE] revealed Resident #5 had bruising to BUE. Review of a skin assessment dated [DATE] revealed Resident #5 did not have bruising. Review of a skin assessment dated [DATE] revealed Resident #5 did not have bruising. Review of a skin assessment dated [DATE] revealed Resident #5 did not have bruising. Observation on 05/17/26 at 3:10 P.M. revealed Resident #5 had scattered bruising to her right hand and forearm. Resident #5 stated the bruises were from the hospital. Interview on 05/26/26 at 9:35 A.M. with LPN #164 confirmed Resident #5 had scattered bruising to BUE. LPN #164 stated they were keeping an eye on the bruising. Interview on 05/26/26 at 10:39 A.M. with the DON confirmed Resident #5's assessments on 05/06/26, 05/17/26, and 05/25/26 indicated Resident #5 did not have bruises and the documentation was inaccurate. Review of a policy titled Charting and Documentation dated 08/2008 revealed all services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the record for Resident #56 revealed an admission date of 02/06/24 and diagnoses including chronic obstructive pulmonary disease, chronic kidney disease, diabetes, and bipolar disorder. Record review revealed a physician's order 07/09/25 to change oxygen tubing and set up weekly on dayshift on Thursday and as needed. Observations on 05/17/26 at 9:10 A.M. revealed Resident #56 to have oxygen on per nasal cannula at two liters. The oxygen tubing was dated 04/02/26 and the humidifier bottle was dated 03/26/26. Interview with LPN #119 on 05/17/26 at 9:30 A.M. confirmed the oxygen tubing was dated 04/02/26 and the humidifier bottle was dated 03/26/26. Review of the oxygen administration record for Resident #56 revealed it was documented that the oxygen tubing and set up had been changed on 04/09/26, 04/16/26, 04/23/26, 04/30/26, 05/07/26, and 05/14/26. Interview with Assistant Director of Nursing #189 on 05/18/26 at 1:00 P.M. confirmed it had been documented six times that the oxygen tubing and set up had been changed when it was not (dated 04/02/26). She confirmed the record was not accurately documented. Interview with LPN #121 on 05/18/26 at 1:15 P.M. confirmed that she documented that Resident #56's oxygen tubing and set up was changed on 04/09/26, 04/23/26, and 05/07/26, when it was not. She confirmed the record was not accurately documented. Interview with LPN #105 on 05/19/26 at 9:43 A.M. confirmed that she documented that Resident #56's oxygen tubing and set up was changed on 04/16/26 and 05/14/26 when it was not. She confirmed the record was not accurately documented. 4. Review of the record for Resident #13 revealed an admission date of 05/07/25 and diagnoses including Parkinson's disease, hypertension, and anxiety disorder. Review of a Minimum Data Set assessment completed 05/07/26 revealed a brief interview for mental status score of 15, indicating intact cognition. It further indicated he was dependent upon staff for personal hygiene, dressing, and showers and required substantial/maximal assistance with transfers. Review of the plan of care revised 08/14/25 revealed Resident #13 required assistance with activities of daily living and mobility. Resident #13 had a physician's order 6/7/25 for nurses to trim and file nails every week on day shift with skin checks. Observations on 05/17/26 at 9:21 A.M. revealed Resident #13 to have long fingernails with a dark substance under the nails. He stated his fingernails needed cut. Observations on 05/18/26 at 8:00 A.M. and 11:19 A.M. revealed the resident to have long fingernails with a dark substance under the nails. He stated the nurses usually cut his nails and they need cut (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	now. Review of the Treatment Administration Record for May 2026 revealed LPN #105 had documented that Resident #13's nails were trimmed and filed on 05/15/26 (2 days before originally noted to be long with dark substance underneath on 05/17/26). Observations on 05/18/26 at 2:20 P.M. revealed Resident #13 to be in bed with long fingernails with a dark substance under the nails. Interview with Assistant Director of Nursing #189 revealed nails are cut weekly by nurses if the resident is a diabetic. She confirmed they did not look like they had been trimmed on 05/15/26 as documented. She asked the resident if he preferred his nails long or short and he replied short. Interview with LPN #105 on 05/19/26 at 9:43 A.M. revealed she did not trim Resident #13's nails on 05/15/26 even though she documented on the treatment record that she did. She confirmed the record was not accurately documented.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure a resident receiving an anti-depressant received education on the risks and benefits of taking that medication to allow them to provide informed consent. This affected one resident (#44) of five residents reviewed for unnecessary medications. Findings include: Review of Resident #44's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included unspecified dementia with mood disturbance, depression, and anxiety disorder. 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. Review of Resident #44's contact list on her admission Record (Face Sheet) revealed her emergency contact/ resident representative was an attorney that was appointed her legal guardian. Review of Resident #44's active physician's orders revealed she had an order in place to receive Remeron (an anti-depressant) 7.5 milligrams (mg) by mouth (po) every night at bedtime for dementia. The order originated on 04/11/26. The resident was also receiving the following psychotropic medications: Zoloft (an anti-depressant) 100 mg po every morning for major depressive disorder, Ativan 0.5 mg po three times a day for anxiety/ agitation related to depression, and Ativan 0.5 mg po every four hours as needed (prn) for anxiety/ agitation. Review of Resident #44's Informed Consents for the Use of Psychotropic Medications provided for review by the facility's Director of Nursing (DON) revealed the resident's daughter was provided education on the risks and benefits associated with the use of Ativan on 03/27/26 and gave an informed consent for that medication to be used. An Informed Consent for Use of Psychotropic Medication pertaining to the use of Zoloft revealed informed consent was received from the resident for the use of that medication on 03/17/26. The form was not signed by the resident to provide evidence an informed consent was obtained. The resident's medical record was absent for any documented evidence that an informed consent was obtained from the resident's legal guardian for the use of Remeron, after it had been initiated as one of the resident's psychotropic medications on 04/11/26. On 05/20/26 at 2:40 P.M., an interview with the director of nursing (DON) confirmed there was no evidence of an informed consent being obtained from Resident #44's legal guardian for the use of Remeron, before it was initiated on 04/11/26. She acknowledged informed consent for the use of psychotropic medications should be obtained, prior to the initiation of the medication. Review of the facility's policy on Psychotropic Medication Consents (not dated) revealed the facility would ensure informed consent was obtained prior to the initiation of psychotropic medications, except in emergency situations consistent with applicable law and clinical standards. The purpose of the policy was to ensure residents or their representatives were informed of the risks, benefits, alternatives, and potential side effects associated with psychotropic medication use and to promote resident rights, safety, and appropriate medication management. The procedure for informed consent indicated the physician or licensed practitioner would discuss with the resident and/ or their representative the medication name and purpose, the target symptoms/ behaviors, risks and potential side effects, benefits and expected outcomes, non-pharmacological interventions attempted, alternative treatment options, and right to refuse treatment. The informed consent was to be obtained prior to initiating a psychotropic medication. The informed consent discussion and consent would be documented in the medical record.		

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. Based on review of resident financial records, record review, staff interview, and family interview, the facility failed to maintain a system that assured a full and complete accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. This affected one resident (#25) of seven residents whose funds were handled by the facility. The facility census was 56. Findings include: Review of the record for Resident #25 revealed an admission date of 01/30/23 and diagnoses including psychosis, paranoid personality disorder, delusional disorder, and Alzheimers disease. Review of a Minimum Data Set assessment completed 05/09/26 revealed a brief interview for mental status score of seven, indicating severe cognitive impairment. Review of financial records revealed the facility handled the resident's personal funds. Review of a Resident Statement Landscape for Resident #25 for the past three months revealed on 05/07/26 \$970.00 was deducted from the resident's account for personal needs items. This left a balance of \$1000.44 in the account. Interview with Business Office Manager #186 on 05/26/26 at 12:30 P.M. revealed the facility had no receipts for any items purchased with the \$970.00. She stated the money was intended to be used to purchase a television and other personal items for Resident #25 by her family. However, the money was not used and was never actually taken out of the account. She stated the money was supposed to be credited back to the resident's personal account handled by the facility but had not been, as of 05/26/26. Interview with Business Office Manager #186 on 05/26/26 at 12:30 P.M. confirmed the financial records for Resident #25 did not accurately reflect how much money she should have in her personal funds account handled by the facility. Interview with Resident #25's daughter on 05/26/26 at 1:00 P.M. revealed there had been a plan to buy the resident some personal items, including a television. She stated she was first told the facility had to cut a check for the money. She stated she was never aware of how much money was going to be taken out of the account and did not know how \$970.00 was decided upon. She stated she had asked Business Office Manager #186 last week about the money and she was told there was no money in the resident's account. She stated she had not received any funds from the resident's account and did not ask any further questions about the resident's personal funds.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure resident's medical provider was notified regarding change in condition. This affected two residents (#1 and #21) of two residents reviewed for change in condition. The facility census was 56. Findings include: 1. Record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including pneumonia due to mycoplasma pneumoniae and acute posthemorrhagic anemia. Review of a minimum data set (MDS) assessment dated [DATE] revealed Resident #1 had mildly impaired cognition, had no behaviors, and received continuous oxygen therapy. Review of a care plan dated 02/09/26 revealed Resident #1 required oxygen therapy related to chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and acute on chronic respiratory failure. The goal was for Resident #1 to have no signs or symptoms of poor oxygen absorption through the review date. Interventions included but were not limited to change resident's position frequently to facilitate lung secretion movement and drainage; give medications as ordered; monitor for signs and symptoms of respiratory distress and report to provider including respirations, pulse oximetry, increase heart rate, restlessness, diaphoresis, headaches, lethargy, confusion, atelectasis, hemoptysis, cough, pleuritic pain, accessory muscle usage and skin color; oxygen setting at 2 liter per minute (lpm) via nasal cannula; promote lung expansion and improve air exchange by positioning with proper body alignment and elevate head of bed to 30 degrees. Review of a nursing note dated 02/17/26 at 5:13 A.M. by Registered Nurse (RN) #225 revealed Resident #1's oxygen was in the low 70's this shift. RN #225 was teaching him to breathe in his nose and out his mouth. Resident #1 stated he could hardly take a deep breath. There was no evidence Resident #1's medical provider was contacted regarding low oxygen saturation. Review of a nursing note dated 02/17/26 at 10:58 A.M. by the Director of Nursing (DON) revealed Resident #1's oxygen saturation was at 80% which exceeded a low of 90%. The respiratory nurse was notified to go evaluate Resident #1 on possible use of incentive spirometer. There was no evidence Resident #1's medical provider was notified regarding low oxygen saturations. Review of a nursing note dated 02/17/26 at 3:17 P.M. by RN #168 revealed per nursing report at 6:00 A.M., Resident #1's oxygen dropped to 80%, oxygen was increased to six liters per minute (lpm) per nasal cannula via nasal cannula and oxygen saturation increased to 90%. Upon assessment at 6:30 A.M., oxygen saturation was 89-90% on six lpm via nasal cannula. Lungs had scattered rhonchi and a nonproductive cough. Inhalers were administered per orders, and as needed nebulizer treatment was administered this shift. Resident was assessed and treated by the respiratory therapist and participated in physical therapy at bedside without complications. Resident #1 was resting in bed at this time with a call light in reach. A call was received by infectious disease provider stating resident's hemoglobin was 6.3 and wanted to make sure Physician #195 was aware and treating. An urgent message was left for Physician #195 at 11 A.M., and the facility was awaiting a response. There was no evidence Resident #1's medical provider was notified regarding low oxygen saturations. Interview on 05/20/26 at 1:09 P.M. with Physician #195 revealed he should be notified any time oxygen saturation is in the 70s and staff should document any rechecks of oxygen levels. Physician #195 did not recall being notified of Resident #1's oxygen dropping into the 70s or staff increasing oxygen to six lpm. Physician #195 stated they should notify him of that, not necessarily before due to it being emergency, but he should be made aware as soon as possible. Physician #195 stated he was not made aware of respiratory struggles and if he had know about that in conjunction with the low hemoglobin, which he was aware (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Kimes Nursing and Rehab LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 75 Kimes Lane Athens, OH 45701	
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of, he would likely have requested for Resident #1 to be sent to the emergency department due to possible need of blood transfusion. Interview on 05/26/26 at 10:32 A.M. with the director of nursing (DON) revealed when Resident #1 was desaturating to 80% on 02/17/26, she did not send him out or call the doctor because they tried to address concerns in-house first since he had COVID, pneumonia and low hemoglobin. The DON stated low hemoglobin can impact breathing. The DON stated she had not been aware of the nursing note prior to hers on 02/17/26 which stated Resident #1 was desaturating into the low 70s but stated she could not speak on behalf of the nurse for not calling the doctor. 2. Record review revealed Resident #21 was admitted to the facility on [DATE] with diagnoses including other pericardial effusion and cardiac tamponade. Review of a minimum data set (MDS) dated [DATE] revealed Resident #21's memory was severely impaired, had no behaviors, and did not have oxygen or a bipap/cpap. Review of a care plan dated 04/22/26 revealed Resident #21 had altered respiratory status/difficulty breathing related to sleep apnea. The goal was for resident #21 to have no complications related to shortness of breath through the review date. Interventions included but were not limited to administer medications and puffers as ordered and monitor for effectiveness and side effects; assist resident in learning signs of respiratory compromise; CPAP settings: 04/13 via full facemask; encourage sustained deep breaths by using demonstration, using incentive spirometer, or asking resident to yawn; maintain a clear airway by encouraging resident to clear own secretions with effective coughing, if secretions cannot be cleared, suction as ordered/required to clear; nebulizer treatments as ordered. Review of a nursing note dated 05/04/26 at 8:00 A.M. by Licensed Practical Nurse (LPN) #164 revealed the nightshift nurse (LPN #181) informed her during report that Resident #21's oxygen had been low all night ranging from 70's to 80's. An aide (Certified Nurse Aide (CNA) #152) obtained vitals which were out of normal range and resident was lethargic. Upon assessment of lungs, rales were present bilaterally. Vitals were blood pressure of 150/122 (normal range 120/80 mm/Hg), pulse of 91, oxygen saturation still ranging from 80's to 90's and respiration of 25. Physician #195 was notified and gave new orders to send to the emergency room. An ambulance was called to transfer resident to the emergency room. Interview on 05/17/26 at 2:49 P.M. with LPN #164 revealed she came to the facility on [DATE] and was told by LPN #181 that Resident #21's oxygen saturation had been low all night, she did not send her out, call the doctor or document anything. LPN #164 stated the first thing she and the CNA did was round and take vitals which were abnormal. The physician was contacted and gave an order to send the resident out. Interview on 05/18/26 at 2:13 P.M. with Physician Assistant (PA) #190 revealed the facility does not have an on-call service after hours because Physician #195 prefers to take care of his own orders. PA #190 stated the expectation if a resident is having abnormal vital signs would be to complete a comprehensive assessment of the resident and call him or Physician #195 for orders. PA #190 stated it would be abnormal for a resident who usually has oxygen saturations in the 90s to have saturation below 88%. The assessment should include checking all vitals, checking lung sounds, and checking for accessory muscle use. PA #190 stated abnormal vital signs would depend on the resident's baseline. PA #190 stated if a resident who was not alert and oriented would not wear their c-pap and had oxygen saturations in the 70's to 80's, the provider should be contacted and the resident should be sent out. PA #190 stated he would think a nurse should document incidents. Interview on 05/19/26 at 5:44 A.M. with LPN #181 revealed Resident #21 does not like to wear her c-pap and moves around a lot so it is hard to keep on. LPN #181 stated on nightshift 05/03/26 to 05/04/26, Resident #21 did not want to wear her c-pap and the CNA (#132) checked on her around 1:00 A.M. and noticed low oxygen saturations. The aide asked LPN #181 to go to the rehab unit to check on her and they were able to convince Resident #21 to wear her c-pap and her saturations started to rise. LPN #181 stated the (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lowest she saw Resident #21's saturations was 85%. LPN #181 stated she thought CNA #132 had checked all of Resident #21's vitals but she did not document anything. LPN #181 stated she did listen to Resident #21's lung sounds. LPN #181 confirmed she did not document anything at all for Resident #21 on 05/03/26 to 05/04/26 and should have. Interview on 05/19/26 at 1:36 P.M. with the Director of Nursing (DON) confirmed the nightshift nurse (LPN #181) did not complete any kind of assessment or progress note for Resident #21 during her shift (05/03/26-05/04/26). Interview on 05/20/26 at 1:30 P.M. with Physician #195 revealed he did not recall being notified of anything regarding Resident #21 on 05/04/26 nightshift. He stated he would want to be notified of oxygen saturations in the 70's and provide a full assessment of all vital signs and lung sounds. Review of a policy titled Change in a Resident's Condition of Status dated 12/2016 revealed the facility shall promptly notify the resident, his or her attending physician, and representative of changes in the resident's medical/mental condition and/or status.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure proper notices were given to residents when skilled services were ending. This affected three residents (#1, #4, and #69) of five residents reviewed for beneficiary notices. The facility census was 56. Findings include: 1. Record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including other lack of coordination, muscle weakness, and chronic obstructive pulmonary disease. Review of a Beneficiary Protection Notification Review form revealed Resident #1's skilled stay at the facility began on 11/12/25 and his last covered day was 12/12/25. The facility initiated the discharge from Medicare Part A Services when benefit days were not exhausted. A Notice of Medicare Non Coverage (NOMNC) was not issued because resident's discharge plan was to go home. 2. Record review revealed Resident #4 was admitted to the facility on [DATE] with diagnoses including congestive heart failure, muscle weakness, and lack of coordination. Review of a Beneficiary Protection Notification Review form revealed Resident #4's skilled services began on 10/29/25 and ended on 12/02/25. The facility initiated the discharge from Medicare Part A Services when benefit days were not exhausted. A NOMNC was not issued because resident's discharge plan was to go home. 3. Record review revealed Resident #69 was admitted to the facility on [DATE] with diagnoses including cerebral ischemia, muscle weakness, and lack of coordination. Review of a care plan dated 02/26/26 revealed Resident #69's discharge plan was to stay in the facility for long term care. The goal was to voice satisfaction with long term care placement. Interventions included give resident the opportunity to express feelings about long-term care placement and identify needs for successful long-term care placement. Review of a Beneficiary Protection Notification Review revealed Resident #69's skilled stay began on 11/06/25 and ended on 12/19/25. The facility initiated the discharge from Medicare Part A services when benefit days were not exhausted. A NOMNC was provided, but an advanced beneficiary notice (ABN) was not. Review of a NOMNC dated 12/19/25 revealed Resident #69's skilled services would end on 12/19/25. The notice was given on 12/17/25, 48 hours in advance. Interview on 05/18/26 at 9:24 A.M. with Business Office Manager (BOM) #186 revealed NOMNCs for Resident #1 and #4 were not completed because she was not aware they had to be completed for residents who were discharging home after they were cut from Medicare coverage. BOM #186 stated she received no training on completing NOMNCs or ABNs and thought they were meant to be given for part B services. BOM #186 stated there was not an ABN completed for Resident #69. Review of an undated policy titled Notice of Medicare Non-Coverage (NOMNC) Policy revealed the facility will provide Medicare beneficiaries and/or their representative with a valid NOMNC when Medicare-covered skilled services are ending in accordance with Centers for Medicare & Medicaid Services (CMS) requirements. The facility will ensure residents are informed of their right to appeal the termination of coverage and that all required documentation and timelines are followed. The NOMNC must be issued two calendar days before Medicare coverage ends or no later than the day before discharge if services are less than two days. The notice will be provided to the resident or representative. Staff will explain date Medicare coverage ends, appeal rights, and potential financial responsibility after coverage ends. A copy of the NOMNC will be filed in the medical record.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review, policy review, and staff interview, the facility failed to ensure the resident/resident representative was provided written notice, at the time of transfer for hospitalization, that specified the duration of the bed-hold policy. This affected one resident (#62) of one resident whose closed record was reviewed for hospitalization. The facility census was 56. Findings include: Review of the record for Resident #62 revealed an admission date of 02/09/26 and diagnoses including cerebral infarction with hemiplegia, diabetes, rheumatoid arthritis, and hypertension. Review of a Minimum Data Set assessment completed 02/15/26 revealed a brief interview for mental status score of 15, indicating intact cognition. Review of nursing progress notes on 02/09/26 revealed the resident arrived at the facility after a stay at a rehab hospital. On 03/04/26 it was documented that staff spoke with the resident and her husband about discharging to another facility by 03/10/26 or remaining in the facility for long term placement. The note stated wants to explore other options closer to home. Writer agreed to reach out to surrounding facilities to seek long term placement that accepts Medicaid pending. On 03/04/26 at 5:47 P.M. it was documented the resident was transferred to the hospital for stroke like symptoms including left side facial drooping and slurred speech. The physician was in the facility and ordered stat baby aspirin to be given while waiting for the squad. Resident #62 to did not return to the facility. There was no evidence the resident or her representative was provided with written notice of the bed hold policy at the time of transfer to the hospital. Interview with Business Office Manager #186 on 05/20/26 at 3:20 P.M. confirmed there was no evidence written notice of the bed-hold policy was provided to Resident #62 or her representative at the time of transfer to the hospital. She stated she just realized a week ago that the facility was not providing written notice of the bed-hold policy upon transfer. Review of the facility policy dated 11/28/25 titled readmission to the Facility revealed, at the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident or the resident representative written notice specifying the duration of bed-hold policy, and the opportunity to pay the bed- hold if allowed by State Plan.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure Minimum Data Set (MDS) assessments were completed accurately in the areas of vision/ corrective lenses and medications received during the assessment period. This affected three residents (#6, #7, and #44) of 27 residents reviewed for MDS assessments. Findings include:1. Review of Resident #6's medical record revealed the resident was admitted to the facility on [DATE]. His diagnoses included adult- onset diabetes mellitus. Review of Resident #6's active physician's orders revealed he had orders to receive Mounjaro (a GIP and GLP-1 receptor agonist used to treat adult-onset diabetes mellitus by triggering insulin release to lower blood sugar when it was high) 2.5 milligrams (mg)/ 0.5 milliliters (ml) with instructions to inject 2.5 mg subcutaneously in the morning once a week on Thursdays. The order had been in place since 02/24/26. The resident did not have an order to receive any insulin injections to manage her adult-onset diabetes mellitus. Review of Resident #6's annual MDS assessment dated [DATE] revealed the resident was coded on the MDS assessment as having received an injection seven out of the seven day assessment period (04/09/26- 04/15/26). It also indicated that the resident received insulin injections seven of the seven days of the assessment period. Review of Resident #7's medication administration record (MAR) for April 2026 revealed no evidence of the resident receiving insulin injections between 04/09/26 and 04/15/26, as was indicated on his annual MDS assessment completed on 04/15/26. The only injection the resident received was his weekly Mounjaro injection that was not classified as insulin. Review of drug information for Mounjaro from MedScape revealed the medication was in the class of an anti-diabetic. It was a Glucagon-like Peptide-1 agonist. It was a hormone that induced insulin secretion in response to a meal to facilitate the metabolism of carbohydrates, fats, and proteins and also increased insulin secretion in the presence of elevated blood glucose levels. It in itself, was not considered insulin. On 05/20/26 at 4:10 P.M., an interview with Registered Nurse (RN) #175 revealed she was the facility's MDS nurse. She acknowledged Mounjaro was not considered an insulin and should not have been coded as such, on Resident #6's annual MDS assessment completed on 04/15/26. She verified she had indicated on the MDS assessment that the resident was given injections and insulin on seven of the seven days of the assessment period, when only Mounjaro had been given once weekly as ordered. She reported she would have to do a modification of the annual MDS assessment to ensure it accurately reflected medication classifications that the resident received. 2. Review of Resident #44's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included unspecified dementia and an infrarenal (an anatomical term meaning below the kidneys) abdominal aortic aneurysm (ballooning in the wall of an artery) without rupture. Review of Resident #44's active physician's orders revealed the resident had an order in place to (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	receive Plavix (an anti-platelet medication used in the prevention of blood clots) 75 mg by mouth (po) every morning for an antiplatelet related to her diagnosis of infrarenal abdominal aortic aneurysm. The order originated on 03/14/26. The resident did not have an order to receive any other blood thinning medications to include an anticoagulants, such as Eliquis or Coumadin. Review of Resident #44's significant change MDS assessment dated [DATE] revealed the resident's medications received during the seven day assessment period (04/17/26- 04/23/26) were coded under section (N.). The resident was coded on the MDS assessment as having received an anticoagulant and not an antiplatelet, despite her only having an order to receive Plavix. Review of Resident #44's MAR's for April 2026 revealed the resident was given Plavix 75 mg po once daily in the morning between 04/17/26 and 04/23/26. There was no indication on the MAR of the resident having been given an anticoagulant between 04/17/26 and 04/23/26, as indicated on the significant change MDS. On 05/20/26 at 4:10 P.M., an interview with RN #175 confirmed Resident #44's significant change MDS that was completed on 04/23/26 was not coded accurately to reflect the proper medication classifications that had been received. She acknowledged Plavix was considered an antiplatelet medication and should not have been coded as the resident receiving an anticoagulant. She reported she had already received education from their corporate nurse that Plavix was not an anticoagulant, when it was brought to the facility's attention that the resident's medications were not accurately indicated on the resident roster matrix. She indicated she would have to submit a modification for the significant change MDS to ensure it accurately reflected the medications the resident received. 3. Review of the record for Resident #7 revealed an admission date of 01/13/26 and diagnoses including acute and chronic respiratory failure, schizoaffective disorder, hypertension, and anxiety disorder. Review of an admission Minimum Data Set (MDS) assessment 01/19/26 and a quarterly MDS assessment 04/21/26 revealed the resident's vision was adequate with no corrective lenses. The MDS on 04/21/26 had a brief interview for mental status score of 15, indicating intact cognition. Review of nursing progress notes on 05/04/26 at 8:54 P.M. revealed the resident's son requested an eye doctor appointment be scheduled to get replacement glasses for the resident. Interview with Resident #7 on 05/17/26 at 3:23 P.M. revealed she wears glasses but does not have any as they were left at the last facility she was at prior to admission. She stated she would like new glasses. Interview with Social Service Staff #130 on 05/20/26 at 9:54 A.M. revealed she was aware that Resident #7's son had requested for her to receive vision services. Interview with MDS Nurse #175 on 05/20/26 at 10:10 A.M. revealed she asks staff if a resident wears glasses to know how to mark the MDS for corrective lenses. She did not indicate that she asks the resident or their family about corrective lenses. She confirmed the MDS indicated the resident did not use corrective lenses. She further confirmed this was inaccurate if the resident wears glasses.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure Pre-Assessment Screenings and Resident Reviews (PASARRs) were accurate and updated to reflect new mental health diagnoses. This affected three residents (#6, #40, and #53) of four residents reviewed for PASARRs. The facility census was 56. Findings include: 1. Record review revealed Resident #40 was to the facility on [DATE] with diagnoses including major depression and anxiety disorders. A new diagnosis of psychotic disorder was added on 03/28/24. Review of a PASARR completed 09/28/23 revealed no indications of Resident #40 having mental health diagnoses. Review of a care plan revised on 07/14/25 revealed Resident #40 had mood deficits related to the death of her son and grandson, psychotic disorder, depression, anxiety, insomnia, and Parkinson's disease. The goal was for the resident to not have any complications related to anxiety or depression through the review period. Goals included but were not limited to approach resident in a warm and pleasant manner, consult physician and/or psych services as needed, explain all procedures before carrying out, if disruptive to others assist away to a quiet area and allow resident to become calm, medications per orders and monitor for side effects, monitor for signs and symptoms of distress, one on one visit for emotional support at least monthly, take time with resident allow time for responses as needed, and provide support, reassurance and tend love and care. Review of a minimum data set (MDS) assessment dated [DATE] revealed Resident #40's cognition was mildly impaired, had a depression scale which reflected mild depression, and had no behaviors. 2. Record review revealed Resident #53 was admitted to the facility on [DATE] with diagnoses including bipolar disorder. Review of a care plan dated 03/02/26 revealed Resident #53 had a mood stabilizer medication related to bipolar disorder. The goal was to be free from discomfort or adverse reactions related to mood stabilizer therapy through review date. Interventions included but were not limited to administer medication as ordered; educate resident about risks, benefits, and side effects and/or toxic symptoms; monitor for side effects; and monitor/record occurrence of target behavior symptoms: mania. Review of an MDS dated [DATE] revealed Resident #53's cognition remained intact, had minimal depression, and had no behaviors. Review of a PASARR completed 03/26/26 revealed Resident #53 had other psychotic disorder but mood disorder was blank. Interview on 05/19/26 at 11:03 A.M. with Admissions Director (AD) #162 revealed Resident #40's (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR did not have psychotic disorder, anxiety, or depression listed. AD #162 stated she completed PASARRs within 29 days of admission or with a significant change. AD #162 stated she was not aware of change in Resident #40's diagnoses. AD #162 also confirmed Resident #53 does not have a psychotic disorder and bipolar should have been listed as a mood disorder, but she had not been aware bipolar disorder was a mood disorder. Review of a policy titled PASARR Policy revealed all admissions will be screened through the PASARR process prior to admission except for exempted hospital discharges as permitted by regulations. A level I PAS will be completed to identify indicators of serious mental illness, intellectual disability, and related conditions. If the level I is positive, the resident will be referred for a level II PASARR evaluation. Residents requiring a level II evaluation may not be admitted until PASARR determination and recommendations are completed, except when permitted under provisional or exempted admission categories. The facility will maintain the PAS in the medical record, follow all recommendations and specialized service requirements, and notify appropriate entities of significant changes requiring PASARR review. 3. Review of Resident #6's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included paranoid personality disorder, delusional disorder, generalized anxiety disorder, and major depressive disorder. Paranoid personality disorder and delusional disorder had been included under his diagnoses list since 04/29/23. Review of Resident #6's PASARR Identification Screen completed on 05/10/26 revealed he was identified as having a mood disorder and panic or other severe anxiety disorder under his known diagnoses that were indications of serious mental illness. Personality disorder and delusional disorder were not marked as being known diagnoses for the resident despite him having both diagnoses on his diagnoses list since 04/29/23. Review of Resident #6's PASARR Result Notice dated 05/10/26 revealed, based on the PASARR Identification Screen submitted, the resident did not have any indications of a serious mental illness and/ or a developmental disability. There was not a referral made for a Level II evaluation to determine if the resident required any specialized services during his stay in the facility. On 05/26/26 at 8:47 A.M., an interview with Admissions Director #162 revealed she was the employee that had completed Resident #6's PASARR that was done on 05/10/26. She confirmed the PASARR was not completed accurately, as she did not identify the resident as having delusional disorder or personality disorder on that PASARR under section (E.) Indications of Serious Mental Illness. She stated she had been working to update some of the residents' PASARR's, since last week, when it was brought to their attention that other residents' PASARR's had not been completed accurately. She stated the facility was looking at having their MDS Coordinator complete the PASARR's moving forward. She was not sure why she did not mark delusional disorder or personality disorder as being known mental disorder diagnoses on the resident's PASARR and indicated she must have just missed it. Review of the facility's policy on PASARR (Preadmission Screening and Resident Review) not dated revealed the facility would comply with all federal and state PASARR requirements to ensure (continued on next page)		

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

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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.			
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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	individuals with serious mental illness were appropriately screened prior to admission or upon significant change in condition. The purpose was to ensure compliance with PASARR regulations, appropriate placement, and identification of specialized service needs for residents entering or residing in the facility.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to ensure a resident with known edema to her bilateral lower extremities (BLE) had a care plan developed to address her edema and another resident's care plan for being at risk for falls was implemented. This affected two residents (#28, #44) of 27 residents reviewed for care plans. Findings include: 1. Review of Resident #28's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease, dementia with behavioral disturbances, neurocognitive disorder with Lewy Bodies, HTN, muscle weakness, and abnormalities of gait and mobility. Review of Resident #28's annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's cognition was severely impaired. She was usually able to make herself understood and was usually able to understand others. She was not noted to display any behaviors, nor was she known to reject care. She had limited range of motion (ROM) in her BLE. Review of Resident #28's active care plans revealed she had a care plan in place for a self care performance deficit with activities of daily living (ADL's). The resident was indicated to be dependent on staff for dressing and required the assist of two if combative. Her active care plans did not address any known issues with edema (swelling) in her BLE. Review of Resident #28's active physician's orders revealed she had an order in place to elevate her BLE when in bed and to where compression stockings to her BLE when out of bed. Both orders originated on 05/14/26. On 05/17/26 at 1:00 P.M., an observation of Resident #28 noted her to be up in her wheelchair sitting in the TV/ lounge area near the nurses' station. Her BLE were noted to be edematous (swollen) and she was not noted to be wearing any compression stockings. Her legs were not elevated and in a dependent position with her feet resting on the floor. On 05/18/26 at 10:51 A.M., a follow up observation of Resident #28 noted her to be up in her wheelchair in the dining room. Her BLE remained in a dependent position, without the presence of any compression stockings, and her feet were in direct contact with the floor. On 05/18/26 at 1:14 P.M., an interview with Certified Nursing Assistant (CNA) #176 revealed she had worked at the facility for two months now and was typically assigned on the North or the South halls. She was working on Resident #28's hall that day and was familiar with the resident. She was not aware of the resident having any swelling in her legs. She checked the Kardex (information available to the aides in the computer that specified resident care needs) in the computer and did not note the resident had the use of any compression stockings. She reported the only thing listed in the Kardex for Resident #28 was the use of geri-sleeves (protective sleeves used to prevent skin tears). She reported night shift had gotten the resident up that morning, which was confirmed by CNA #131, who was her partner working the South hall on that day. CNA #131 indicated she was aware Resident #28 was supposed to have compression stockings on when out of bed, but denied noticing whether she had them on or not, when observing her up earlier. The two aides denied they were the one's who helped the resident get back into bed following lunch. They reported the facility's ADON and another employee were the ones who helped the resident back into bed, after lunch. They were asked to check Resident #28's room to see if she had any compression stockings in her room. They searched her dresser drawers and the bathroom and could not find them. CNA #176 indicated they were often hung on the grab bars in the bathroom, when not in use, but did not find them hanging there. On 05/18/26 at 1:25 P.M., an interview with Registered Nurse (RN) #189/Assistant Director of Nursing (ADON) confirmed Resident #28 has been having some issues with swelling in her BLE. She confirmed an order was written on 05/14/26 for the use of compression (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stockings. She acknowledged the resident was observed for the past two days, without compression stockings being on, when out of bed. She further acknowledged a care plan to address the resident's edema in her BLE was not initiated. As a result, the use of compression stockings when out of bed was not on the resident's Kardex, which was used by the aides to direct care that needed to be provided to the resident. She was asked who helped her get the resident into bed, after lunch. She identified Licensed Practical Nurse (LPN) #121 as being the staff member that helped her put the resident in bed following lunch. On 05/18/26 at 1:30 P.M., an interview with LPN #121 confirmed she was the one who assisted RN #189 with placing Resident #28 into bed following lunch. She denied the resident had compression stockings on her BLE when up and as ordered to manage her lower extremity edema. She denied she was aware of there being any refusals by the resident on wearing compression stockings that day. She did refuse the day before, but denied that being the case on that day. 2. Review of Resident #44's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included muscle weakness, abnormalities of gait and mobility, lack of coordination, need for assistance with personal care, hypertension, and unspecified dementia with mood disturbance. Review of Resident #44's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had moderately impaired cognition. She was not known to have rejected any care during the seven day assessment period. She had a functional limitation of her range of motion ROM in her bilateral upper and lower extremities and used a wheelchair as a mobility device. She required a substantial/ maximum assist with transfers and ambulation did not occur. She was identified as having fallen twice since her last assessment. One was without injury and the other was with injury that was not major injury. 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, cognitive impairment, incontinence, impaired mobility, weakness, psychotropic drug use, and history of falls. The goals were for the resident to not experience significant injury from a fall, maintain her highest level of independence with mobility and maintain safety, reducing fall occurrences and the possibility of injury through staff intervention. The interventions included the use of Dycem (a tacky material placed under a resident to prevent slipping out of a chair) to her recliner to prevent sliding out of recliner. That intervention was added on (03/24/26. She also had an intervention to ensure appropriate footwear when out of bed. That intervention was 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 wheelchair in the TV/ lounge area by the nurses station. RN #123 was asked to assist the resident back to her room so it could be verified if the resident had Dycem in place under her when sitting in her reclining wheelchair. The nurse had an aide assist her with standing the resident up and it was determined that there was not a piece of Dycem under the resident, while she was up in her reclining wheelchair to prevent her from sliding out of the chair, as per her plan of care. The nurse reported she would have to get the resident some Dycem to put in the reclining wheelchair. The resident did not have any other recliners in her room and it was verified by the nurse that the Dycem was intended to be used under the resident when in her wheelchair. On 05/20/26 at 1:25 P.M., a second observation was made of Resident #44 while she was up in her wheelchair in the TV/ lounge area across from the nurses station. The resident was noted to be wearing socks on her feet and did not have slippers with a non-skid sole that she was previously observed to be wearing during other observations. Findings were verified by RN #123. She checked the bottom of Resident #44's socks and confirmed they were not non-skid socks. She acknowledged the resident's fall prevention care plan indicated she was to have appropriate footwear on when out of bed. She went back to the resident's room and retrieved her (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	slippers that had a non-skid sole and assisted the resident with putting them on. The resident thanked the nurse for bringing her shoes and allowed them to put 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.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, interviews, and policy review, the facility failed to ensure residents requiring assistance with hygiene services received showers, facial hair removal, and nail care. This affected three residents (#13, #30, and #40) of five residents reviewed for activities of daily living (ADLs). The facility census was 56. Findings include: 1. Record review revealed Resident #30 was admitted to the facility on [DATE] with diagnoses including dementia and depression. Review of a care plan dated 07/15/25 revealed Resident #30 had a self-care and mobility performance deficit related to confusion, dementia, and muscle weakness. The goals were for risk for decline for ADL function to minimize through the review date and continue to have needs met on a daily basis through the review date. Interventions included but were not limited to assist as needed with shower twice weekly or per resident preference and personal hygiene assist: dependent with assistance from one helper. Review of a minimum data set (MDS) assessment dated [DATE] revealed Resident #30's cognition was severely impaired, she did not have behaviors and was dependent on staff for personal hygiene. Observation and interview on 05/17/26 at 4:48 P.M. with Resident #30's family revealed the resident had multiple long, gray hairs on her chin. Resident's daughter stated she would not like to have hairs on her because Resident #30 was always very put together, still wears makeup daily, and was in beauty pageants when she was younger. Resident's daughter stated she had brought in tweezers and asked the activities staff to help get her chin cleaned up but no one had yet. Interview on 05/18/26 at 10:22 A.M. with Activities Director (AD) #145 revealed Resident #30's daughter provided tweezers a week ago and asked for resident's chin hair to be plucked. AD #145 stated she had not completed the task yet because she is afraid of bruising resident. AD #145 confirmed Resident #30 had a good bit of chin hair and it was important for her to look nice. Interview on 05/18/26 at 1:25 P.M. with AD #145 revealed she plucked Resident #30's chin hairs and resident reported feeling much better. 2. Record review revealed Resident #40 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. Review of a care plan dated 07/14/25 revealed Resident #40 had a self-care and mobility performance deficit related to weakness, osteoporosis, pain, Parkinson's disease, and impaired mobility. The goals were for decline to be minimized through the review and to continue to have needs met on a daily basis through the review date, remaining clean, dry, dressed, groomed, and free of odors. Interventions included but were not limited to assist with showers twice weekly or per resident preference and maximum assistance of one staff for showers. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an MDS dated [DATE] revealed Resident #40's cognition was mildly impaired, she did not have behaviors and required maximum assistance for showers. Review of showers revealed Resident #40's shower schedule was Sunday and Wednesday. Resident #40 did not receive her scheduled showers on 04/29/26 or 05/06/26. Interview on 05/18/26 at 8:32 A.M. with Resident #40 revealed she was not getting her showers. Interview on 05/20/26 at 8:29 A.M. with Registered Nurse (RN) #170 confirmed Resident #40 did not receive two of her showers. 3. Review of the record for Resident #13 revealed an admission date of 05/07/25 and diagnoses including Parkinson's disease, hypertension, and anxiety disorder. Review of a Minimum Data Set assessment completed 05/07/26 revealed a brief interview for mental status score of 15, indicating intact cognition. It further indicated he was dependent upon staff for personal hygiene, dressing, and showers and required substantial/maximal assistance with transfers. Review of the plan of care revised 08/14/25 revealed Resident #13 required assistance with activities of daily living and mobility. Resident #13 had a physician's order dated 06/07/25 for nurses to trim and file nails every week on day shift with skin checks. Observations on 05/17/26 at 9:21 A.M. revealed Resident #13 to have white facial hair and long fingernails with a dark substance under the nails. He stated his fingernails needed cut and it had been several days since he had been shaved. He stated he requires assistance from staff with shaving. Observations on 05/18/26 at 8:00 A.M. and 11:19 A.M. revealed the resident to have white facial hair and long fingernails with a dark substance under the nails. He stated they usually shave him when he gets a shower but has not been shaved for a week. He stated the nurses usually cut his nails and they need cut now. Review of the Treatment Administration Record for May 2026 revealed Licensed Practical Nurse (LPN) #105 had documented that Resident #13's nails were trimmed and filed on 05/15/26 (two days before originally noted to be long with dark substance underneath on 05/17/26). Review of shower records revealed his last shower was documented on 05/14/26. Observations on 05/18/26 at 2:20 P.M. revealed Resident #13 to be in bed with white facial hair and long fingernails with a dark substance under the nails. Assistant Director of Nursing (ADON) #189 confirmed the resident had facial hair. She stated nails are cut weekly by nurses if the resident is a diabetic. She confirmed they did not look like they had been trimmed on 05/15/26 as documented. She asked the resident if he preferred his nails long or short and he replied short. She asked him if he was growing a beard or if he preferred being shaved and he replied shaved. She stated his shower days are Sunday and Thursday and he would be shaved on those days. She confirmed he was not documented as receiving a shower on Sunday 05/17/26 as scheduled. (That would indicate four days (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	without being shaved). Interview with LPN #105 on 05/19/26 at 9:43 A.M. revealed she did not trim Resident #13's nails on 05/15/26 even though she documented on the treatment record that she did.		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on record review, staff interview, resident interview, and contract review, the facility failed to ensure that residents received proper treatment and assistive devices to maintain vision abilities by assisting with making appointments and/or arranging for transportation to and from practitioner's offices. This affected two residents (#7, #13) of three residents reviewed for communication/sensory impairment. The facility census was 56. Findings include: 1. Review of the record for Resident #7 revealed an admission date of 01/13/26 and diagnoses including acute and chronic respiratory failure, schizoaffective disorder, hypertension, and anxiety disorder. Review of an admission Minimum Data Set (MDS) assessment 01/19/26 and a quarterly MDS assessment 04/21/26 revealed the resident's vision was adequate with no corrective lenses. The MDS on 04/21/26 had a brief interview for mental status score of 15, indicating intact cognition. Review of an ancillary services form revealed the facility provides in-house ancillary services for the residents. Resident #7 had agreed to receive vision services on 01/14/26. Review of nursing progress notes on 05/04/26 at 8:54 P.M. revealed the resident's son requested an eye doctor appointment be scheduled to get replacement glasses for the resident. Interview with Resident #7 on 05/17/26 at 3:23 P.M. revealed she wears glasses but does not have any as they were left at the last facility she was at prior to admission. She stated she would like new glasses but has not seen an eye doctor since admission. Interview with Social Service Staff #130 on 05/20/26 at 9:54 A.M. revealed she was aware that Resident #7's son had requested for her to receive vision services. She stated the resident had consented upon admission to seeing the facility mobile eye doctor, who visits the facility, for vision services. She stated the mobile vision service the facility contracts with was last at the facility in December 2025. She stated there was no set schedule for the eye doctor to visit the facility. She stated she had contacted them two weeks ago to determine when they would visit the facility but they did not provide a date. She stated she had not contacted any local eye doctors to attempt to get the resident an appointment. Interview with the Administrator on 05/20/26 at 4:00 P.M. confirmed the contract for vision services says services shall be rendered at times mutually agreed upon by the vision provider and facility to ensure residents access to medically necessary services. He confirmed they do not have mutually agreed upon times and should have. Review of the facility contract for in-house vision services dated 10/24/23 revealed services shall be rendered at times mutually agreed upon by the vision provider and the facility to ensure the facility residents access to medically necessary services. 2. Review of the record for Resident #13 revealed an admission date of 05/07/25 and diagnoses including Parkinson's disease, diabetes, anxiety disorder, and hypertension. Review of an in-house vision consult report dated 12/22/25 revealed Resident #13 was present for evaluation of dry eyes in the right and left eyes and for diabetic eye exam. Patient is interested in glasses but the right eye won't read due to cataract and the left eye won't read due to poor corneal surface. Will treat and recheck next visit. The note stated the dry eye syndrome was significant and to treat with artificial tears one drop both eyes three times daily. The consult note stated to return in 1-3 months for cornea eval. There was no evidence the resident every received the artificial tears eye drops recommended 12/22/25. There was no evidence he was seen again by the eye doctor. Review of a Minimum Data Set assessment of 05/07/26 revealed a brief interview for mental status score of 15, indicating intact cognition. Interview with Resident #13 on 05/18/26 at 8:00 A.M. revealed he saw the in-house eye doctor about six or more weeks ago. He stated they told him he needed eye drops but he has not gotten any yet. Interview with Social Worker (SW) #130 on 05/18/26 at 2:43 P.M. confirmed Resident #13 was seen by the in-house eye doctor on 12/22/25. She stated nursing was sent a copy of the recommendations by the eye (continued on next page)		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	doctor. She stated the in-house eye doctor had not been back to the facility since 12/22/25 and he had not been seen again in 1-3 months as recommended. She stated she did not know when they were coming to the facility again. Interview with Assistant Director of Nursing #189 on 05/18/26 at 2:55 P.M. confirmed Resident #13 had not received any eye drops as recommended by the eye doctor.		

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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. 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 (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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)		

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	
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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 (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interview, the facility failed to ensure residents received necessary respiratory care and services. This affected two residents (#21, #56) of four residents reviewed for respiratory care. The facility census was 56. Findings include: 1. Review of the record for Resident #56 revealed an admission date of 02/06/24 and diagnoses including chronic obstructive pulmonary disease, chronic kidney disease, diabetes, and bipolar disorder. Record review revealed a physician's order dated 07/09/25 to change oxygen tubing and set up weekly on dayshift on Thursday and as needed. Review of the oxygen administration record for Resident #56 revealed it was documented that the oxygen tubing and set up had been changed on 04/09/26, 04/16/26, 04/23/26, 04/30/26, 05/07/26, and 05/14/26. Observations on 05/17/26 at 9:10 A.M. revealed Resident #56 to have oxygen on per nasal cannula at two liters. The oxygen tubing was dated 04/02/26 and the humidifier bottle was dated 03/26/26. Interview with Licensed Practical Nurse (LPN) #119 on 05/17/26 at 9:30 A.M. confirmed the oxygen tubing was dated 04/02/26 and the humidifier bottle was dated 03/26/26. He stated the tubing was to be changed every week. He stated he was not sure how often the humidifier bottle was to be changed. Interview with Assistant Director of Nursing (ADON) #189 on 05/18/26 at 1:00 P.M. confirmed it had been documented six times that the oxygen tubing and set up had been changed when it was not (dated 04/02/26). She stated the oxygen tubing and humidifier bottle should be changed weekly. Interview with LPN #121 on 05/18/26 at 1:15 P.M. confirmed that she documented that Resident #56's oxygen tubing and set up was changed on 04/09/26, 04/23/26, and 05/07/26, when it was not. She stated she had no excuse for why it was not done. Interview with LPN #105 on 05/19/26 at 9:43 A.M. confirmed that she documented that Resident #56's oxygen tubing and set up was changed on 04/16/26 and 05/14/26 when it was not. She stated she did not know why she did not change it. 2. Record review revealed Resident #21 was admitted to the facility on [DATE] with diagnoses including pericardial effusion and hypothyroidism. Review of a Minimum Data Set, dated [DATE] revealed Resident #21's cognition was severely impaired. Review of an order dated 05/13/26 revealed Resident #21 had oxygen at 3 liter per minute via nasal cannula continuously. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/17/26 at 2:41 P.M. revealed Resident #21 was sitting in her wheelchair in her room with oxygen nasal cannula in place, but the concentrator was completely off. Resident #21 stated she was having a hard time breathing. This surveyor got Certified Nursing Assistant (CNA) #152 who came into the room and confirmed the oxygen was off. CNA #152 turned the concentrator on and it returned to three liters per minute.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure pharmacy recommendations that were generated from irregularities noted during residents' monthly medication regimen reviews were addressed and/ or responded to timely by the attending physician. This affected two residents (#6, #25) of five residents reviewed for unnecessary medications. Findings include: 1. Review of Resident #6's medical record revealed the resident was admitted to the facility on [DATE]. His diagnoses included chronic obstructive pulmonary disease (COPD), generalized anxiety disorder, major depressive disorder, paranoid personality disorder, and delusional disorder. Review of Resident #6's monthly medication regimen reviews revealed the resident's medications were reviewed monthly for the past 12 months for irregularities. The monthly medication regimen reports showed irregularities were noted in the resident's medication regimen in September 2025 and again in April of 2026. Review of the pharmacy recommendation based on the monthly medication regimen review completed on 09/09/25 revealed the facility's consulting pharmacist had recommended the physician review the resident's use of Valium and Buspar, both of which were antianxiety medications, and requested that the physician consider a gradual dose reduction (GDR) attempt. The pharmacist indicated the resident had been on Valium 5 milligrams (mg) twice a day, since 07/07/23. The resident was indicated to have been on Buspar 10 mg three times a day since 09/20/23. There was no evidence of the physician responding to the recommendation until a second recommendation pertaining to the same was made on 02/13/26. Further review of Resident #6's pharmacy recommendations revealed the consulting pharmacist had made a recommendation to the nursing staff pertaining to the resident's use of Advair (a corticosteroid and a bronchodilator given by inhalation to control COPD symptoms). The recommendation from the pharmacist was for the nursing staff to add the need for the resident to rinse his mouth with water and to spit out the contents per the manufacturer's recommendation to reduce the risk of oral thrush (a rash inside the mouth caused by a fungal infection). There was not evidence of that nursing recommendation from the pharmacist to be followed up on. Review of Resident #6's active physician's orders for May 2026 revealed the resident had an order to receive Advair Diskus Inhalation Aerosol Powder Breath Activated 100-50 micrograms (mcg)/ actuate with directions to inhale one puff orally two times a day related to COPD. The order had been in effect since 01/04/26. The order did not include any special instructions for the resident to rinse his mouth with water and spit after use to reduce his risk for oral thrush, as was recommended by the pharmacist during the monthly medication regimen reviews completed in April 2026. Findings were verified by the Director of Nursing (DON). On 05/26/26 at 1:00 P.M., an interview with the DON confirmed she could not find documented evidence of Resident #6's physician addressing the pharmacy recommendation pertaining to the resident's use of Valium and Buspar that was made in September 2025, until a second pharmacy (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recommendation concerning the same was repeated in February 2026. She acknowledged that was not considered a timely response from the physician. She further confirmed the nursing recommendation made in April 2026 pertaining to the need to rinse and spit after the use of Advair was not acted upon. She reported she would go ahead and add that to the resident's current Advair order as requested by the pharmacist. She acknowledged the risk of oral thrush, when using an inhaler containing corticosteroids, as part of the resident's treatment for COPD. 2. Review of the record for Resident #25 revealed an admission date of 01/30/23 and diagnoses including psychosis, paranoid personality disorder, delusional disorder, major depressive disorder, Alzheimers disease, and post traumatic stress disorder. Review of physician's orders revealed an order for an antidepressant (Wellbutrin SR 150 milligrams daily in the morning) on 08/08/25. Review of a Note to Attending Physician from the pharmacist on 08/11/25 revealed to please evaluate and consider modification of the current Wellbutrin SR dose: Wellbutrin XR is intended to be administered in a single daily dose while Wellbutrin SR tablets are meant to be given in divided doses. Please evaluate and consider changing to the following order: Wellbutrin XL 100 mg every day. On 08/20/25 the physician documented on the note to attending physician to change the Wellbutrin to XL 150 milligrams every morning. There was no evidence the order to change the Wellbutrin was implemented. As of 05/20/26, the order remained Wellbutrin SR 150 milligrams daily in the morning. Review of a Note to Attending Physician from the pharmacist on 10/07/25 revealed to please evaluate and consider modification of the current Wellbutrin SR dose: Wellbutrin XR is intended to be administered in a single daily dose while Wellbutrin SR tablets are meant to be given in divided doses. Please evaluate and consider changing to the following order: Wellbutrin XL 150 mg every day. There was no evidence the physician responded to the pharmacy irregularity identified on 10/07/25. Review of a Consultant Pharmacist's Medication Regimen Review Recommendations Pending a Final Response on 11/24/25 revealed to please evaluate and consider modification of the current Wellbutrin SR dose: Wellbutrin XR is intended to be administered in a single daily dose while Wellbutrin SR tablets are meant to be given in divided doses. Please evaluate and consider changing to the following order: Wellbutrin XL 150 mg every day. On 11/24/25 the physician documented that the resident was tolerating the current dose but did not document why the medication could not be changed as per pharmacy recommendation. Review of a Note to Attending Physician on 01/09/26 revealed to please evaluate and consider modification of the current Wellbutrin SR dose: Wellbutrin XR is intended to be administered in a single daily dose while Wellbutrin SR tablets are meant to be given in divided doses. Please evaluate and consider changing to the following order: Wellbutrin XL 150 mg every day. On 01/10/26 the physician documented that this medication was a stimulant, not a medical restraint. The physician did not address why the medication could not be changed as recommended by the (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pharmacist. Record review also revealed the pharmacy had identified irregularities during the March 2026 medication review. However, the irregularities identified were not available. Interview with the Director of Nursing on 05/19/26 at 4:25 P.M. revealed she was unable to find the pharmacy irregularities identified for Resident #25 in March 2026. She confirmed the response to change the Wellbutrin to XL by the physician on 08/20/25 was never carried out and the resident stayed on the SR dose to present. She confirmed there was no response by the physician to the 10/07/25 irregularity. She confirmed the responses by the physician on 11/24/25 and 01/10/26 did not address what the pharmacist had identified.		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure lab results were obtained as ordered. This affected one resident (#1) of one resident reviewed for low hemoglobin. The facility census was 56. Findings include: Record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including pneumonia due to mycoplasma pneumoniae and acute posthemorrhagic anemia. Review of orders revealed Resident #1 had an order in place dated 02/01/26 for albuterol sulfate inhalation aerosol solution 108 (90 base) micrograms (mcg)/ACT two puffs every four hours as needed for chronic obstructive pulmonary disease. Review of a minimum data set (MDS) dated [DATE] revealed Resident #1 had mildly impaired cognition, had no behaviors, and received continuous oxygen therapy. Review of a care plan dated 02/09/26 revealed Resident #1 required oxygen therapy related to chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and acute on chronic respiratory failure. The goal was for Resident #1 to have no signs or symptoms of poor oxygen absorption through the review date. Interventions included but were not limited to change resident's position frequently to facilitate lung secretion movement and drainage; give medications as ordered; monitor for signs and symptoms of respiratory distress and report to provider including respirations, pulse oximetry, increase heart rate, restlessness, diaphoresis, headaches, lethargy, confusion, atelectasis, hemoptysis, cough, pleuritic pain, accessory muscle usage and skin color; oxygen setting at 2 liter per minute (lpm) via nasal cannula; promote lung expansion and improve air exchange by positioning with proper body alignment and elevate head of bed to 30 degrees. Review of a nursing note dated 02/12/26 at 12:33 P.M. by Licensed practical nurse (LPN) #222 revealed new orders were received for a COVID test, flu test, and a complete blood count (CBC). All parties were made aware and no further updates at this time. Review of a nursing note dated 02/12/26 at 3:02 P.M. by LPN #222 revealed Resident #1 tested positive for COVID. Vital signs were checked and he had a blood pressure of 118/54, heartrate of 64, temperature of 99.7, respirations of 18, and oxygen was 93% on four liters per minute. Resident #1 had sediment and dark red colored urine draining from colostomy. Findings were reported to a physician and care plan monitoring was ongoing. Review of a nursing note dated 02/12/26 at 4:35 P.M. by LPN #222 revealed Resident #1's labs came back with a critical result of hemoglobin at 6.8 which was reported to the physician. New orders were received to send Resident #1 out for further evaluation. Resident and his daughter were aware, and he transferred to a local emergency room. Report was called to the emergency room and no other updates at this time. Review of hospital notes dated 02/12/26 revealed Resident #1 presented with a chief complaint of abnormal labs. His hemoglobin was 6.8. Resident #1 complained of a dry cough but denied other concerns. Guaiac results were negative. A CT scan revealed bilateral lower lobe airspace opacities were suspicious for pneumonia. An x-ray revealed moderate infiltrate perhaps from pneumonia in the right lung base and slight pneumonitis in the right upper lobe. Resident #1 was given intravenous normal saline bolus, Rocephin, and azithromycin while in the emergency room. A repeat CBC showed his hemoglobin at 7.1. Review of a nursing note dated 02/17/26 at 3:17 P.M. by RN #168 revealed per nursing report at 6:00 A.M., Resident #1's oxygen dropped to 80%, oxygen was increased to six lpm via nasal cannula and oxygen saturation increased to 90%. Upon assessment at 6:30 A.M., oxygen saturation was 89-90% on six lpm via nasal cannula. Lungs had scattered rhonchi and a nonproductive cough. Inhalers were administered per orders, and as needed nebulizer treatment was administered this shift. Resident was assessed and treated by the respiratory therapist and participated in physical therapy at bedside without complications. Resident (continued on next page)		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#1 was resting in bed at this time with a call light in reach. A call was received by infectious disease provider stating resident's hemoglobin was 6.3 and wanted to make sure Physician #195 was aware and treating. An urgent message was left for Physician #195 at 11 A.M., and the facility was awaiting a response. Review of a lab note dated 02/17/26 at 3:45 P.M. by RN #189 revealed Resident #1's lab which were drawn on 02/16/26 were abnormal including a critically low hemoglobin of 6.3, red blood count of 2.37, platelet count of 115, sed rate of 34, sodium of 132, albumin of 2.5, calcium of 8.3, CK of 32, blood urea nitrogen (BUN) of 42.1, creatinine of 1.72, and glucose of 230. Physician #195 was aware and gave new orders for further lab work to be drawn tomorrow (02/18/26). Resident #1's daughter was aware. Review of a nursing note dated 02/17/26 at 4:29 P.M. by RN #168 revealed Resident #1 had new orders for labs including a CBC with retic count, iron and iron binding capacity to be collected on 02/18/26 and run stat to local hospital, with a lavender and gold top tube and the code is low hemoglobin. Resident's daughter was aware. Review of a nursing note dated 02/18/26 at 1:24 P.M. by LPN #127 revealed CBC, retic, iron and iron binding capacity were drawn and sent to a local hospital with a facility driver. The facility was awaiting results and Resident #1 tolerated the blood draw well. Review of a nursing note dated 02/19/26 at 3:57 P.M. by Registered Nurse (RN) #184 revealed lab results were sent to infectious disease provider per orders. Physician #195 was notified of low hemoglobin with no new orders. Review of a nursing note dated 02/20/26 at 3:26 A.M. by LPN #229 revealed Resident #1 had an order for occult blood times three bowel movements, document results every shift for three days. There was no additional information. Review of a nursing note dated 02/20/26 at 6:02 P.M. by RN #184 revealed a new order was received for Resident #1 to have occult blood times three bowel movements. Resident did not have a bowel movement this shift. Review of a nursing note dated 02/21/26 at 5:32 P.M. by LPN #227 revealed Resident #1 had an order for occult blood times three bowel movements. Resident #1 did not have a bowel movement this shift. Review of orders revealed Resident #1 had an order in place dated 02/23/26 for hemocult stools for three bowel movements, report positives to physician and discontinue once third sample is obtained. Review of a nursing note dated 02/23/26 at 1:33 P.M. by the director of nursing (DON) revealed Resident #1 received a critical low lab result for hemoglobin of 6.7. Physician #195 was notified and stated he would be in shortly to review and had no new orders at this time. Review of a nursing note dated 02/25/26 at 7:01 A.M. by RN #189 revealed Resident #1 had an order for hemocult stools for three bowel movements and report positives to physician every shift and discontinue once the third sample was obtained. Resident #1 did not have a bowel movement. Review of a nursing note dated 02/25/26 at 10:50 P.M. by RN #189 revealed Resident #1 had an order for hemocult stools for three bowel movements and report positives to physician every shift and discontinue once the third sample was obtained. Resident #1 did not have a bowel movement. Review of a nursing note dated 02/26/26 at 6:37 P.M. by DON revealed Resident #1 had an order for hemocult stools for three bowel movements and report positives to physician every shift and discontinue once the third sample was obtained. Resident #1 did not have a bowel movement. Review of a nursing note dated 02/26/26 at 6:38 P.M. revealed Resident #1 had orders for CBC with retic for one day which would be rescheduled for the morning. Review of a nursing note dated 02/27/26 at 12:34 A.M. by LPN #222 revealed Resident #1 had an order for hemocult stools for three bowel movements and report positives to physician every shift and discontinue once the third sample was obtained. The equipment was not available to obtain the sample. Review of a nursing note dated 02/27/26 at 6:01 P.M. by RN #123 revealed results were received from the CBC with retic and Physician #195 was to review, no new orders at this time. Interview on 05/20/26 at 1:09 P.M. with Physician #195 revealed he ordered iron levels and other labs on 02/17/26 to evaluate cause of low hemoglobin and he does not know what (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Kimes Nursing and Rehab LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 75 Kimes Lane Athens, OH 45701	
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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	happened to those lab results. Physician #195 stated he needs to know the results to try and figure out what is going on with Resident #1 to cause low hemoglobin. Interview on 05/26/26 at 10:32 A.M. with DON revealed she would attempt to locate the labs ordered on 02/18/26 along with occult stools. Review of the labs which were ordered on 02/18/26 revealed they were received by the facility on 05/26/26. The labs indicated Resident #1 had a low iron of 13 (59-158), low TIBC of 141 (170-500), high retic of 2.01 (0.5-2), low hematocrit of 21.8 (40-52), low red blood cells of 2.58 (4.4-5.9), and a critically low hemoglobin of 6.7 (13.3-17.7). The critically low hemoglobin was called in to LPN #227. The occult stools were not provided upon request. Interview on 05/26/26 at 11:53 A.M. with Administrator confirmed the labs which were ordered on 02/18/26 were not received or reviewed by the facility until 05/26/26 and the occult stools were not provided.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, policy review, and review of infection surveillance reports, the facility failed to implement the antibiotic stewardship program to ensure the appropriate use of antibiotics. This affected three residents (#22, #40, and #72) of 27 residents reviewed for infection control concerns. The facility census was 56. Findings include: 1. Review of the record for Resident #72 revealed an admission date of 04/07/26. Review of the facility infection surveillance report for April 2026 revealed Resident #72 had been taken to the hospital by his family for reports of ongoing weakness, agitation, and hallucinations with difficulty urinating. No other symptoms voiced. Diagnosed with urinary tract infection by the hospital and started on an antibiotic. Review of hospital records revealed he presented with increased falls, confusion, and concern for urinary tract infection (did not mention difficulty urinating). The assessment and plan stated: urinary tract infection with urinary incontinence. It stated a urine sensitivity was pending. On 04/06/26 it stated the urine was sensitive to the antibiotic Cipro. He was started on Cipro at the hospital on [DATE]. After admission to the facility on [DATE], the Cipro continued from 04/07/26 to 04/16/26 for a total of 18 doses. (the physician's order was for Cipro 500 milligrams twice daily for 9 more days). Review of the urine culture results from the hospital dated 04/06/26 revealed Resident #72 had 50,000-100,000 CFU/ml of Enterobacter cloacae. Review of nursing progress notes on 04/08/26 at 3:31 A.M. revealed the resident had no signs/symptoms of infection. Interview with Assistant Director of Nursing (ADON) #189 on 05/26/26 at 12:05 P.M. revealed the facility is supposed to complete an Infection Control Surveillance form for residents prescribed antibiotics to determine if the antibiotic is necessary. She confirmed the Infection Control Surveillance form was not complete for Resident #72. She confirmed that the Infection Surveillance form indicated that the criteria for a urinary tract infection included at least 100,000 CFU/ml of an organism and at least one of the following symptoms: acute dysuria or pain, swelling, or tenderness of testes, epididymis or prostate, fever or leukocytosis. She stated the results of urine culture and lack of symptoms were not discussed with the physician to determine if the resident should continue on the antibiotic after admission to the facility. Resident #72 was discharged home on [DATE]. 2. Review of the record for Resident #22 revealed an admission date of 05/03/26. Review of hospital records revealed the resident was admitted to the hospital 04/26/26 with chief complaint of confusion. Notes indicated the resident had urinary frequency and lower abdominal pain. Denied dysuria. Has had watery diarrhea for two weeks with abdominal cramping. Diagnosis of acute metabolic encephalopathy (a sudden disruption of brain function caused by a systemic illness, chemical imbalance, or organ failure) likely secondary to infection. Urine culture pending. Review of the urine culture results revealed 50,000 CFU/ml of Pseudomonas aeruginosa. Upon admission to the facility on [DATE], the resident had physician's orders for an antibiotic (Ceftriaxone sodium injection two grams daily by IV until 05/06/26. The resident received the medication on 05/04/26, 05/05/26, and 05/06/26. Review of the Infection Surveillance Report for May 2026 revealed Resident #22 was listed as having a urinary tract infection with signs and symptoms of dysuria and altered mental status. The bacteria was listed as Pseudomonas aeruginosa. It indicated Ceftriaxone was given. Review of nursing progress notes on 05/04/26 at 4:02 P.M. revealed the resident had no reports of urinary symptoms. Interview with Assistant Director of Nursing #189 on 05/26/26 at 12:05 P.M. revealed the facility is supposed to complete an Infection Control Surveillance form for residents prescribed antibiotics to determine if the antibiotic is necessary. She confirmed the Infection Control Surveillance form was not complete for Resident #22. (continued on next page)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She confirmed that the Infection Surveillance form indicated that the criteria for a urinary tract infection included at least 100,000 CFU/ml of an organism and at least one of the following symptoms: acute dysuria or pain, swelling, or tenderness of testes, epididymis or prostate, fever or leukocytosis. She stated the results of urine culture and lack of symptoms were not discussed with the physician to determine if the resident should continue on the antibiotic after admission to the facility. Record review revealed the resident was sent to hospital 05/14/26 with chest pain and did not return. 3. Review of the record for Resident #40 revealed an admission date of 04/09/24. Review of the Infection Surveillance Report for February 2026 revealed the resident had a urinary tract infection on 02/16/26. It stated the resident had burning on urination, dysuria, and was treated with an antibiotic. It stated the bacteria was E-coli. There was no evidence an Infection Control Surveillance form was completed to determine if the antibiotic was necessary and appropriate. Record review revealed the resident received the antibiotic Bactrim DS for seven days starting on 02/19/26. Interview with Assistant Director of Nursing #189 on 05/26/26 at 12:05 P.M. revealed the facility is supposed to complete an Infection Control Surveillance form for residents prescribed antibiotics to determine if the antibiotic is necessary. She confirmed the Infection Control Surveillance form was not complete for Resident #40. Review of the facility policy dated 2001 and revised December 2016 and titled Antibiotic Stewardship-Review and Surveillance of Antibiotic Use and Outcomes revealed antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship. As part of the facility antibiotic stewardship program, clinical infections treated with antibiotics will undergo review by the infection preventionist (IP), or designee. The IP, or designee, will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics. Therapy may require further review and possible changes if: therapy was started awaiting culture, but culture results and clinical findings do not indicate continued need for antibiotics.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record review, staff interview, and policy review, the facility failed to provide education for and then offer the influenza and pneumonia vaccines for a resident. This affected one resident (#6) of five residents reviewed for vaccines. The facility census was 56. Finding include: Review of the record for Resident #6 revealed an admission date of 01/13/26 and diagnoses including acute and chronic respiratory failure, morbid obesity, hypertension, and schizoaffective disorder. Record review revealed no evidence the resident had been provided education for or offered the influenza and pneumonia vaccines. There was no evidence the resident had received the vaccines previously. Interview with Assistant Director of Nursing #189 on 05/18/26 at 9:35 A.M. revealed Resident #6 should have been offered the influenza and pneumonia vaccines on admission and she could find no evidence that was done. Review of the facility policy dated 2001 and revised August 2008 titled Influenza Vaccine revealed between October 1st and March 31st each year, the influenza vaccine shall be offered to residents, unless medically contraindicated or the resident has already been immunized. Prior to the vaccination, the resident or resident's legal representative will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. Provision of such education shall be documented in the residents' medical record. Review of the facility policy dated 2001 and revised August 2008 titled Pneumococcal Vaccine revealed prior to or upon admission, residents will be assessed for eligibility to receive the Pneumovax and when indicated, will be offered the vaccine within 30 days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. Before receiving the Pneumovax, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the vaccine. Provision of such education shall be documented in the residents' medical record.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review, policy review, and staff interview, the facility failed to provide education for then offer COVID-19 vaccines for a resident. The is affected one resident (#6) of five residents reviewed for vaccines. The facility census was 56. Findings include: Review of the record for Resident #6 revealed an admission date of 01/13/26 and diagnoses including acute and chronic respiratory failure, morbid obesity, hypertension, and schizoaffective disorder. Record review revealed no evidence the resident had been provided education for or offered the COVID-19 vaccines. There was no evidence the resident had received the vaccine previously. Interview with Assistant Director of Nursing #189 on 05/18/26 at 9:35 A.M. revealed Resident #6 should have been offered the COVID-19 vaccine on admission and she could find no evidence that was done. Review of the facility policy dated 05/13/21 and titled COVID-19 Vaccine revealed the COVID-19 vaccine shall be offered to residents, unless medically contraindicated or the resident has already been immunized. Prior to the vaccination, the resident or resident's legal representative will be provided information and education regarding the benefits and potential side effects of the COVID-19 vaccine. Provision of such education shall be documented in the residents' medical record.		