STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366259	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scioto Rehabilitation & Care Center	433 Obetz Road Columbus, OH 43207

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 - Minimal harm or potential for 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 interview, record review, and review of hospital documentation, the facility failed to ensure the physician was notified when intravenous access was not able to be obtained during a change of condition for Resident #130. This affected one resident (#130) of one resident reviewed for change in condition. The facility census was 102. Findings Include:Record review for Resident #130 revealed this resident was admitted to the facility on [DATE], and discharged on 05/15/26, with diagnoses including bipolar disorder, dementia, psychotic disturbance, mood disturbance, and anxiety, diabetes, Parkinson's disease and muscle weakness.Review of the five-day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 15. This resident was assessed to require staff assistance with completing self-care tasks and mobility.Review of the care plan dated 04/21/26 revealed Resident #130 was at risk for a nutritional problem. Interventions included monitoring the resident and the resident's lab work and report to the physician signs of malnutrition.Review of the physician orders for Resident #130 revealed an order dated 05/14/26 at 7:50 P.M. to infuse normal saline 75 milliliters per hour for one liter of fluid.Further review of the medical record for Resident #130 revealed no documented evidence as to why the resident would need a normal saline infusion. Review of Resident #130's progress notes revealed on 05/15/26 at 3:57 A.M. the facility's nursing team was unable to insert an intravenous catheter into Resident #130 to start the ordered saline infusion. The team obtained permission from the Director of Nursing (DON) to contact an outside provider to attempt to insert the intravenous (IV) catheter. Review of the progress notes did not reveal the physician was notified that the order was not being fulfilled.Further review of Resident #130's medical record revealed no documented evidence that an outside provider was contacted or that IV access was obtained or infused while the resident was in the facility. There was also no evidence regarding the residents transfer to the hospital. Review of Resident #130's hospital medical record dated 05/15/26 at 10:31 A.M. revealed the resident presented lethargic, confused and hypoxic, requiring supplemental oxygen (oxygen saturation 88% at time of emergency department admission on [DATE]). Review of the physician notes revealed complications from medication side effects, dehydration/acute kidney injury, and exacerbation of Parkinsons syndrome were considered but the resident was ultimately diagnosed with metabolic encephalopathy and acute kidney injury. She was provided a bolus of IV fluids and appeared significantly better and she was discharged . The resident did not return to the facility. Interview with a family member of Resident #130 on 06/10/26 at 4:44 P.M. confirmed Resident #130 was experiencing weakness and hallucinations on 05/13/26. The resident reported seeing a gunman outside of her window, which no one else observed. She stated the resident was transferred to the hospital on [DATE] as the resident looked ill appearing. An interview on 06/10/26 at 5:40 P.M. with Certified Nursing Assistant (CNA) #227 confirmed on 05/14/26, around 10:00 A.M., Resident #130 reported experiencing stomach discomfort. She was also still experiencing hallucinations. CNA #227 said she immediately reported these observations to the nurse, Registered Nurse (RN) #213.During an Interview with RN #213 on 06/10/26 at 4:15 P.M. he recalled on 05/14/26 a CNA told him the resident had a stomachache and was having trouble urinating. RN #213 completed (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366259	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scioto Rehabilitation & Care Center	433 Obetz Road Columbus, OH 43207

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 - Minimal harm or potential for actual harm Residents Affected - Few	an assessment and called the provider who ordered the IV. He stated night shift was to carry out the new order for the IV. During an interview on 06/11/26 at 2:35 P.M. with Physician #27 confirmed there was not a notification to his team that the facility was unable to start the intravenous catheter timely, which meant they were not able to provide the resident was fluids as ordered and timely. He stated he was made aware that Resident #130 was hospitalized in the morning, after that the resident was already sent out, due to a family members request for hospitalization.This deficiency represents noncompliance investigated under Complaint Number 3029033.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366259	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scioto Rehabilitation & Care Center	433 Obetz Road Columbus, OH 43207

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a resident record review, staff interview and review of a facility policy, the facility failed to ensure that a resident's protein supplement was administered per orders to promote wound healing. This affected one resident (#12) out of three residents reviewed for pressure ulcers. The facility census was 102 residents.Findings include: Review of a resident record revealed Resident #12 was admitted to the facility on [DATE] and had diagnoses that included acute respiratory failure with hypoxia and anoxic brain damage. Review of Resident #12's care plan dated 08/25/25 revealed that Resident #12 was at risk for a nutritional problem related to being reliant on enteral nutrition as a sole source of nutrition support, skin impairment and being enrolled in hospice services. An intervention listed was to provide and serve supplements as ordered starting on 09/08/25. Review of Resident #12's nutrition assessment dated [DATE] revealed that it was recommended to add ProStat (a nutrition supplement that provides 15 grams of protein per 30 milliliters and promotes tissue healing) 30 milliliters (ml) twice daily for additional protein and skin integrity support. Review of Resident #12's pressure ulcer assessment dated [DATE] revealed that Resident #12 had a stage III (broken through the top two layers of skin) pressure ulcer on her right buttock that was discovered on 10/04/25. Review of Resident #12's physician orders dated 10/29/25 revealed that Resident #12 was prescribed ProStat 60 ml for additional protein and skin integrity support via gastrostomy tube once daily due at 6:00 P.M. Review of Resident #12's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident's cognition could not be assessed. Resident #12 was assessed as having a gastrostomy tube and receiving over 51% of her estimated caloric needs via gastrostomy tube. Resident #12 was assessed as having one unhealed stage IV pressure ulcer (full thickness tissue loss). Review of Resident #12's April Medication Administration Record (MAR) revealed that Resident #12 was given 30 ml instead of 60 ml on 18 out of 30 administrations. Review of Resident #12's May MAR revealed that Resident #12 was given 30 ml instead of 60 ml on 25 out of 31 administrations. Review of Resident #12's June MAR revealed that Resident #12 was given 30 ml instead of 60 ml on 9 out of 10 administrations. An interview with Licensed Practical Nurse (LPN) #160 on 06/11/26 at 8:20 A.M. confirmed that LPN #160 administered Prostat to Resident #12 via her gastrostomy tube in a total daily amount of 30 ml. LPN #160 revealed that the usual orders were for 30 ml via gastrostomy tube. An interview with the Director of Nursing on 06/11/26 at 8:24 A.M. confirmed that Prostat was frequently administered at 30 ml instead of 60 ml. An interview with Diet Technician #311 on 06/10/26 at 11:29 A.M. revealed that not receiving a liquid protein supplement as ordered could affect the wound healing process. Review of a facility policy titled, Skin and Wound Management, revised on January 2025, revealed that nurses will ensure that orders, interventions and treatments for skin and wounds are implemented as ordered. This deficiency represents noncompliance investigated under Complaint Number 3022566 and 3012559.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366259	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scioto Rehabilitation & Care Center	433 Obetz Road Columbus, OH 43207

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of resident medical records, observations, interviews, and review of facility policies, the facility failed to meet the nutritional recommendations and had a delay in implementing nutrition recommendations for Resident #89. Additionally, the facility did not provide enteral feedings as ordered for Resident #96. This affected two residents (#89 and #96) out of three residents reviewed for nutrition.Findings include: 1. a. Review of the medical record revealed Resident #89 was admitted to the facility on [DATE] and had diagnoses that included tracheostomy and gastrostomy statuses and protein calorie malnutrition. Review of Resident #89's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #89 had a Brief Interview for Mental Status (BIMS) score of 15, indicative of intact cognitive status. Resident #89 was assessed as having a feeding tube that meets over 51% of Resident #89's estimated calorie needs daily. Review of Resident #89's care plan dated 12/01/25 revealed the resident was at risk for nutritional problems related to gastrostomy status, dysphagia, and the resident relied on the percutaneous endoscopic gastrostomy (PEG) tube as a sole source of nutritional support. Interventions included to provide tube feed as ordered, dietician to evaluate and make diet change recommendations as needed, and administer medications as ordered.Review of Resident #89's Nutrition assessment dated [DATE] revealed that Resident #89 was NPO (unable to eat food by mouth), 143 pounds (lbs) and receiving an enteral feeding of Jevity 1.5 calories at 55 milliliters (ml) per hour (hr) via gastrostomy tube. The enteral feedings were well tolerated and provided Resident #89 with 1974 calories per day, which was meeting 100% of Resident #89's caloric needs. The recommendation was to continue the same enteral and nutrition plan of care. Review of Resident #89's physician orders, that were transcribed into the medical record by Licensed Practical Nurse) LPN Unit Manager #72 dated 01/07/26 and discontinued on 01/30/26, revealed that Resident #89 was ordered Jevity 1.5 calories at 25 ml per hour continuous tube feeding via gastrostomy tube. Review of Resident #89's nursing progress notes revealed no indication for enteral feeding intolerance and no documentation about why Resident #89's enteral nutrition feeding rate was changed to 25 ml/hr on 01/07/26. Review of Resident #89's nutrition progress notes dated 01/29/26 revealed that Resident #89's weight was stable at 144.3 lbs. Resident #89 was receiving Jevity 1.5 calories at 25 ml/hr continuous rate, and the dietitian recommended to change Resident #89's enteral nutrition orders to Jevity 1.5 calories (cal) at 55 ml/hr as previously ordered. Review of Resident #89's physician order dated 01/30/26 revealed that the dietitian clarified the resident's tube feeding order as Jevity 1.5 cal at 55 ml/hr continuous. Review of Resident #89's weight on 02/08/26 revealed that Resident #89 weighed 135.2 lbs. Review of Resident #89's nutrition progress notes dated 02/12/26 revealed that Resident #89 had lost a significant amount of weight of 5.7% in less than one month. The current physician order of Jevity 1.5 cal at 55 ml/hr continuous feeding was in place as previously recommended and it was recommended to continue with current nutrition plan of care. An interview with Diet Technician #311 on 06/10/26 at 10:19 A.M. confirmed that Jevity 1.5 cal at 25 ml/hr would have provided Resident #89 with 898 calories per day from 01/07/26 to 01/30/26 which would have provided Resident #89 with approximately 50% of his estimated caloric needs daily and could have led to significant weight loss. Diet Technician #311 revealed that Resident #89 did not have any enteral feeding intolerances to the previous continuous enteral regimen of Jevity 1.5 cal at 55 ml/hr. An interview with Licensed Practical Nurse (LPN) Unit Manager #172 on 06/10/26 at 2:20 P.M. revealed that he did not recall why he transcribed the order for Resident #89 to receive Jevity 1.5 cal at 25 ml/hr on 01/07/26. LPN Unit Manager #172 confirmed that Resident #89 received Jevity 1.5 cal at 25 ml/hr from 01/07/26 to 01/30/26. To his knowledge, Resident #89 did not have any intolerance to Jevity 1.5 cal at 55 ml/hr as received prior to 01/07/26. b. Review of weights from 02/17/26 through 05/17/26 revealed that Resident #89 steadily gained weight until he weighed 146.9 lbs on 05/17/26. Review of nutrition progress note dated 04/10/26 revealed that the dietitian (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366259	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scioto Rehabilitation & Care Center	433 Obetz Road Columbus, OH 43207

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recommended to increase Resident #89's protein supplement to 30 milliliters (ml) twice daily. Review of the nutrition progress note dated 04/28/26 revealed that the dietitian re-recommended to increase Resident #89's protein supplement to 30 ml twice daily. Review of nutrition progress note dated 05/01/26 revealed that the dietitian was awaiting the pending recommendation for Resident #89's protein supplement to 30 ml twice daily. Review of Resident #89's physician orders revealed that Resident #89 was prescribed a protein supplement 30 ml twice daily on 05/15/26, over a month after the initial recommendation was made by the dietitian. An interview with Licensed Practical Nurse (LPN) Unit Manager #172 on 06/10/26 at 2:20 P.M. revealed that he met with the diet technician weekly and reviewed nutrition recommendations. The LPN confirmed Resident #89's protein supplement 30 ml twice daily was started untimely on 05/15/26. 2. Review of a resident medical record revealed Resident #96 was admitted to the facility on [DATE] and had diagnoses that included cerebral infarction, hemiplegia and gastrostomy status. Review of Resident #96's care plan dated 02/10/26 revealed the resident was at risk for nutritional problems related to gastrostomy status, dysphagia, and the resident relied on the percutaneous endoscopic gastrostomy (PEG) tube as a sole source of nutritional support. Interventions included to provide tube feed as ordered, dietician to evaluate and make diet change recommendations as needed, and administer medications as ordered.Review of Resident #96's MDS 3.0 assessment dated [DATE] revealed Resident #96's cognitive status was unable to be assessed as he was never understood. Resident #96 was assessed as receiving over 51% of his caloric needs via gastrostomy tube and did not have behaviors of being resistant to care. Review of Resident #96's nutrition assessment dated [DATE] revealed that Resident #96 ate nothing by mouth and received Osmolite 1.5 cal at 60 ml/hr continuous enteral feeding to meet 100% of his caloric needs daily. Review of Resident #96's physician orders dated 02/24/26 revealed that Resident #96 was ordered a continuous enteral feeding via gastrostomy tube of Osmolite 1.5 cal at 60 ml/hr. Observations on 06/10/26 from 10:45 A.M. to 11:14 A.M. and from 11:31 A.M. to 11:57 A.M. revealed that Resident #96's enteral feeding pump was not administering the enteral feeding. A red flashing light that read system error was visible on the pump monitor screen. An interview with LPN #160 on 06/10/26 at 11:57 A.M. confirmed that Resident #96's enteral feeding pump was not administering the enteral feeding as ordered. LPN #160 revealed that the enteral feeding had been malfunctioning all day. An observation on 06/10/26 from 2:00 P.M. to 2:12 P.M. revealed that Resident #96's enteral feeding pump was not administering enteral feeding to Resident #96. A yellow flashing light that read feed error was displayed on the monitor. An interview with LPN #160 on 06/10/26 at 2:12 P.M. confirmed that Resident #96's enteral feeding pump line was not administering enteral feeding as ordered. Review of Resident #96's weights revealed that he weighed 107.9 lbs on 02/06/26, the date of his admission. The medical record was silent for monthly weights through 06/09/26. An interview with Diet Technician #311 on 06/10/26 at 10:19 A.M. revealed that she was not aware of any barriers or preferences to weighing Resident #96. Diet Technician #311 revealed that it was her expectation that residents be weighed on a monthly basis at minimum and that Resident #96 had not been weighed since admission. An interview with LPN Unit Manager #172 on 06/10/26 at 2:20 P.M. revealed that he did not know of any barriers to weighing Resident #96 and revealed that residents were weighed monthly. LPN Unit Manager also confirmed Resident #96 had not been weighed since admission. An interview with the Director of Nursing on 06/10/26 at 2:30 P.M. revealed that residents were weighed monthly unless they refused. Review of the facility policy titled, Weight Assessment and Intervention, dated September 2024, revealed that the nursing staff will measure resident weights on admission, then weekly times a total of four weeks. If no weight concerns are noted at that point, weights will be measured monthly thereafter. Any weight change of 5% or more since the last weight will be retaken for confirmation. If the weight change is desirable, this will be documented and no change in the care plan will be necessary. Interventions for undesirable weight loss shall be based on consideration of the following: resident choice and preferences, nutrition and hydration needs of the resident, functional factors, environmental factors, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366259	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scioto Rehabilitation & Care Center	433 Obetz Road Columbus, OH 43207

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	need for diet modifications, use of supplementation and/or feeding tubes. Review of the facility policy titled, Enteral Nutrition, revised January 2014, revealed that the recommendation to use an enteral feeding will be based on the results of the nutritional assessment and be consistent with current standards of practice, treatment goals and facility policies. The dietitian will estimate calorie, protein, nutrient and fluid needs and determine whether the resident's current intake is adequate to meet his or her nutritional needs. The dietitian will monitor residents who are receiving enteral feedings and will make appropriate recommendations for interventions to enhance nutritional adequacy of enteral feedings. This deficiency represents noncompliance investigated under Complaint Number 3022566.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366259	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scioto Rehabilitation & Care Center	433 Obetz Road Columbus, OH 43207

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility policy review, and review of medication labels, the facility failed to ensure a medication error rate below 5 percent (%). Out of 27 opportunities for error, two errors were made to equal a medication error rate of 7.4%. This affected two residents (#29 and #89) of two residents observed for medication administration. The census was 102.Findings include:1. Review of Resident #29's medical record revealed an admission date of 05/18/26. Medical diagnoses include chronic obstructive pulmonary disease, acute diastolic (congestive) heart failure, muscle weakness, obstructive sleep apnea, essential (primary) hypertension, anxiety disorder, depression, gastro-esophageal reflux disease, and acute and chronic respiratory failure with hypoxia. Review of Resident #29's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15.Review of Resident #29's physician orders revealed an order for acetaminophen extended release (ER) oral tablet 650 mg give one tablet by mouth every six hours as needed.Observation on 06/10/26 at 8:25 A.M. with Licensed Practical Nurse (LPN) #160 revealed Resident #29 was given acetaminophen regular strength 650 mg one tablet from the over-the-counter facility supply.Interview on 06/10/26 at 11:45 A.M. with LPN #160 confirmed he gave Resident #29 acetaminophen regular strength 650 mg tablet and not the ordered acetaminophen extended release 650 mg tablet.Review of the facility's policy titled, Medication Administration Policy revised on 02/2026 revealed the individual administering medication checks the label three times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication.2. Review of Resident #89's medical record revealed an admission date of 09/30/25. Medical diagnoses include hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, essential (primary) hypertension, paroxysmal atrial fibrillation, heart failure, gastro-esophageal reflux without esophagitis, gastrostomy status, dysphagia following cerebral infarction, muscle weakness, neuromuscular dysfunction of the bladder, acute and chronic respiratory failure with hypoxia, tracheostomy status, and prediabetes. Review of Resident #89's physician orders revealed an order dated 01/31/26 for a percutaneous endoscopic gastrostomy (PEG) tube flush with 10 cubic centimeters (cc) of water before and after medication administration every shift. Review of Resident #89's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15. Review of Resident #89's MDS section K revealed Resident #89 had a feeding tube in place.Review of Resident #89's care plan revised on 12/01/25 revealed the resident had impaired neurological status related to hemiparesis with interventions to monitor for and report significant changes to neurological status, such as dizziness, to the physician, and administer medications as ordered. Review of Resident #89's physician orders revealed orders for meclizine Hcl oral tablet 25 mg twice daily due at 9:00 A.M. at 9:00 P.M. for dizziness, among multiple other medications due. The order did not state that it was to be crushed, and the order did not state it was a chewable tablet form.Observation and interview on 06/10/26 at 8:55 A.M. with Licensed Practical Nurse (LPN) #160 confirmed she crushed Resident #89's meclizine tablet, among other medications, for administration.Observation of medication administration on 06/10/26 at 9:08 A.M. revealed LPN #160 administered all of Resident #89's crushed medications (including the meclizine tablet) via PEG tube.Interview on 06/10/26 at 12:47 P.M. with Pharmacist #400 confirmed the form of meclizine sent for Resident #89 should not be crushed.Review of the facility's policy, Administering Medications through an Enteral Tube revised on 12/2024 revealed medications were not to be crushed for administration through an enteral tube unless verified with the pharmacy. It noted that tablets that must be crushed prior to administration through an enteral tube required a specific order related to crushing. Review of the meclizine medication label revealed the medication comes in two forms, tablet and chewable tablet. The label noted the medication must be swallowed whole, unless it's the chewable tablet form to which it should be chewed or crushed completely before swallowing.This deficiency represents noncompliance investigated under Complaint Number 3022566.