| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366310 | A. Building<br>B. Wing | 03/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Ohio Living Sarah Moore | 26 North Union Street<br>Delaware, OH 43015 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, staff interview, and policy review, the facility failed to maintain a sanitary kitchen. This had the potential to affect all 42 residents who receive food from the kitchen.Findings include:Observation of the kitchen during the initial tour on 03/16/26 at 8:02 A.M. revealed the ice machine had a brown spots and calcium buildup locates inside and above the ice. Additionally, the floors had a buildup of dirt behind the soda machine and the area behind the dishwasher revealed a black substance which appeared to be mold behind the dishwash area and by the soda dispenser. Dust buildup with a black substance was observed over the food heater located on the area on the ceiling.Interview on 03/16/26 at 8:24 A.M. with [NAME] #155 confirmed all observations regarding the ice machine, floor, dishwash area, and dust buildup over the food heater.Interview on 03/17/26 at 4:36 P.M. with Dietary Manager #162 revealed he does not have any logs of cleaning schedules at this time due but stated he was starting a new cleaning schedule.Review of the facility policy titled General Sanitation of Kitchen, dated 2023, revealed food and nutrition services staff were required to maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule. The procedure outlined that cleaning and sanitation tasks for the kitchen would be assigned to specific positions, with defined frequency for each task. Methods and materials for cleaning and sanitizing were to be written for each task. Employees were to be trained on how to perform cleaning tasks and were required to initial and date tasks on the cleaning schedule when completed. |

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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, medical record review and facility policy review, the facility failed to ensure a care plan was updated for Resident #20 when she began to exhibit behaviors. This affected one (#20) of 16 residents reviewed for care plans. The facility census was 42.Findings include:Review of Resident #20's medical record revealed an admission date of [DATE]. Diagnoses included vascular dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.Review of Resident #20's progress notes dated [DATE] revealed during a quarterly care conference with Resident #20, Resident #20 has moments of confusion looking for her deceased husband and thinking other residents were her husband, but was easily directed.The progress note dated [DATE] revealed Resident #20 had a behavior outburst during an afternoon movie, noting Resident #20 began to get upset and grab onto another resident which she stated was her boyfriend.Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #20 had moderate cognitive impairment. Resident #20 did not exhibit physical behavioral symptoms directed to others, verbal behavioral symptoms directed toward others, and other behavioral symptoms not directed toward others during the review period.Review of Resident #20's care plan on [DATE] revealed the facility did not have a behavior care plan in place for Resident #20.Interview on [DATE] at 2:01 P.M. with Registered Nurse (RN) #106 confirmed there was not a behavior care plan in place for Resident #20.Review of the facility's care plan policy titled Comprehensive Person-Centered Care Planning, dated [DATE], revealed comprehensive care plan is centered on the resident's needs including: measurable objectives and time frames, receiving behavioral health care and services (includes culturally-competent and trauma- informed) to attain or maintain the highest practicable physical, mental, and psychosocial well- being, in accordance with the comprehensive assessment and plan of care. |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, record review, and facility policy review, the facility to ensure the residents received bathing as physician ordered and to maintain their activities of daily living (ADL). This affected one (#20) of two residents reviewed for ADLs. The facility census was 42.Findings include: Review of Resident #1's medical record revealed an admission date of 05/28/25. Diagnoses include bilateral primary osteoarthritis of knee, chronic diastolic (congestive) heart failure, chronic obstructive pulmonary disease, and bilateral nonexudative age-related macular degeneration.Review of the progress notes dated 08/05/25 revealed when Resident #1 refused all care and slept all shift. The medical record did not indicate Resident #1 refused baths or showers from 08/06/26 to 03/15/26. Review of the physician orders dated 09/05/25 revealed Resident #1 should receive bath/shower two times per week, once a day on Wednesday and Saturday.Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #1 had intact cognition. Resident #1's functional abilities revealed Resident #1 required supervision or touching assistance with shower/baths. Resident #1 did not reject care during the review period.Review of Resident #1's shower sheets from 01/01/26 to 02/28/26 revealed Resident #1 received five showers in January 2026 on 01/03/26, 01/17/26, 01/21/26, 01/24/26, and 01/28/26. Resident #1 refused showers on 01/10/26 due to the resident not feeling good and 01/31/26. In February 2026, Resident #1 received a showers on 02/04/26, 02/14/26, and 02/18./26. The shower sheets did not reflect Resident #1 refused personal hygiene on the days she accepted a shower. Resident #1 should have been offered showers according to physician orders on 01/07/26, 01/14/26, 02/07/26, 02/11/26, 02/18/26, 02/25/26, and 02/28/26. Review of the ADL care plan last updated 02/13/26 revealed Resident #1 had the potential for functional status deficit related to physical deconditioning/generalized muscle weakness, advanced age, history of right sided sciatica with intermittent severe right hip pain, right shoulder pain, osteoarthritis of bilateral knees, impaired vision (near complete blindness), moderate hearing difficulty; and chronic pain disorder. Interventions included the resident will receive appropriate staff support with all functional abilities. Approaches included shower/baths required supervision/touching staff assistance. There was no rejection of care noted in the care plan.Interview on 03/16/2026 at 10:24 AM with Resident #1 revealed she was not receiving showers twice a week per schedule.On 03/17/26, the care plan was updated to reflect Resident #1 resisted care often (showers/baths, assistance with personal hygiene-trimming/shaving facial hairs).Interview on 03/18/26 at 4:40 P.M. with Certified Nursing Assistant (CNA) #133 stated shower sheets were to be filled out for each resident's assigned shower day with completion or refusal of a bath or shower.Interview on 03/19/26 at 10:25 A.M. with the Director of Nursing (DON) stated she expected CNAs to fill out a shower/bath sheet for every shower day for every resident with completion or refusal. The DON confirmed Resident #1 received only three baths/showers for February 2026 and there was no additional documents to support Resident #1 received any further showers in February 2026. Review of the facility's policy titled Activities of Daily Living (ADL) dated 07/17/25 revealed it is the policy of the facility to assist each resident to the extent necessary for completion of ADLs on a daily basis and as needed. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure Resident #14, who required staff assistance with activities of daily living (ADL), received adequate and timely care to maintain good personal hygiene including removal of facial hair (shaving). This affected one (Resident #14) of two residents reviewed for ADL. The facility census was 42.Findings include:Review of the medical record for Resident #14 revealed an admission date of 02/16/26. Diagnoses included hemiplegia and hemiparesis following cerebral infarction, cerebral infarction, muscle weakness, and chronic obstructive pulmonary disease.Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #14 had moderate cognitive impairment. Resident #14 was dependent on staff assistance for showering and did not reject care during the review period.Review of the care plan revealed Resident #14 had the potential for functional status deficit related to physical deconditioning, cerebrovascular accident (CVA) with right sided hemiparesis (February 2025), impaired range of motion of right shoulder, generalized muscle weakness, lack of coordination, and moderate cognitive impairment. Interventions included Resident #14 required maximum staff assistance to maintain personal hygiene including combing hair, shaving, applying makeup, washing/drying face and hands.Review of the shower sheets dated 02/17/26, 03/03/26, 03/07/26, and 03/10/26 revealed Resident #14 had not been shaved. There were no other showers sheets from 03/11/26 to 03/16/26.Observation and interview on 03/16/26 at 11:05 A.M. revealed Resident #14 was sitting in her room in her wheelchair with multiple white facial hairs on her chin. Resident #14's spouse stated Resident #14 typically took care of removing the chin hair herself when she was able to.Observation and interview on 03/17/26 at 10:20 A.M. revealed Resident #14 was sitting in her wheelchair in her room with multiple white facial hairs on her chin. Resident #14 stated she wouldn't have chin hair if at home.Interview on 03/17/26 at 10:33 A.M. with Certified Nursing Assistant (CNA) #200 verified Resident #14 had facial hair on her chin. Interview on 03/17/26 at 11:18 A.M. with Licensed Practical Nurse (LPN) #112 stated facial hair on women should be trimmed or shaved if the resident allows them too and should be completed on shower days and as needed. Interview on 03/17/26 at 3:11 P.M. with the Director of Nursing (DON) stated the expectation for facial hair on females was it should be cleaned up just like the men unless the resident refuses and right now there was only one female who refuses (not Resident #14) or resident preference. The DON stated the facial hair should be removed when it is noticed even if it is not a shower day. Review of the facility policy titled Activities of Daily Living (ADL) dated 07/17/25, revealed the facility will assist each resident to the extent necessary for completion o ADLs on a daily basis and as needed. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure wound treatments were timely initiated for a resident with a pressure ulcer. This affected one (Resident #36) of one resident reviewed for skin impairments. The facility census was 42. Findings include:Review of the medical record for Resident #36 revealed an admission date of 02/22/26. Diagnoses included fracture of right pubis, osteoporosis, fracture of sacrum and stage II pressure ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough.) of sacral region. Review of the admission care plan dated 02/22/26 revealed Resident #36 has a ulcer on coccyx. Interventions included pressure-reducing device for chair and bed, surgical wound care and turning and repositioning program. Review of the physician order dated 02/22/26 revealed an order for pressure redistribution mattress to bed and wheelchair. There was no physician order to treat the stage II pressure ulcer. The Braden Scale for pressure ulcer risk, dated 02/22/26, revealed a score of 15, placing Resident #36 at risk for skin impairment. The scoring revealed Resident #36 had no sensory perception impairment, was occasionally moist, was chairfast, had slightly limited mobility, had potential for inadequate nutritional intake, and had concerns related to friction and [NAME] Review of physician visit dated 02/23/26 revealed Resident #36's admitting diagnoses included stage II pressure ulcer on coccyx, and continue to offload to relieve pressure and daily zinc barrier cream. Review of the skin assessment dated [DATE] revealed the stage II pressure ulcer measured 1.8 centimeters (cm) in length, 0.5 cm in width with 0.1 cm in depth. The area showed epithelial tissue, with erythema (redness), with treatment to apply zinc barrier cream. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #36 was moderately cognitively impaired, required substantial/maximal assistance with toileting and was always incontinent of bladder. Resident #37 was identified at risk for pressure areas. From 02/22/26 to 03/01/26, there was no physician order to treat Resident #36's stage II pressure ulcer. The physician orders dated 03/02/26 revealed an order for the coccyx/buttocks gently cleanse, pat dry. Apply zinc barrier cream after each incontinence care every shift. Review of the medication administration records and treatment administration records from 02/22/26 through 03/01/26 revealed Resident #36 did not receive any treatments including zinc barrier cream after each incontinence episode to the stage II pressure ulcer. On 03/02/26, the wound treatments were initiated and documented as completed. The skin assessment dated [DATE] revealed stage II pressure ulcer measured 1.0 centimeters (cm) in length and 0.5 cm in width and 0.1 cm in depth. The area was noted as improving showing epithelial tissue, with erythema (redness), with treatment to apply zinc barrier cream. Interview on 03/18/26 at 8:45 A.M. with Unit Manager #100 revealed she was the nurse who initially assessed Resident #36's wound upon admission and completed routine measuring and monitoring to ensure healing and was responsible for placing physician orders for wound treatments. Interview on 03/18/26 at 11:18 A.M. with the Director of Nursing (DON) confirmed zinc barrier cream was not ordered and documented as completed daily until the physician order was placed on 03/02/26; however, Resident #36's pressure ulcer did not decline. The DON confirmed Unit Manager #100 did not put in the physician order for Resident #36's pressure ulcer when it was initially assessed. The DON confirmed she was unable to provide evidence the skin treatments were performed daily from 02/23/26 through 03/02/26, with an exception of 02/24/26. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, medical record review, fall investigation review, and facility policy review, the facility failed to complete a thorough status post fall investigation when they failed to identify Resident #34's hematoma on his forehead and did not initiate neurological checks per their facility policy. This affected one (Resident #34) of five residents reviewed for accidents. The facility census was 42.Findings include:Review of Resident #34's medical record revealed an admission date 03/17/23. Diagnoses included spinal stenosis, moderate dementia with agitation, chronic systolic (congestive) heart failure, chronic atrial fibrillation, chronic obstructive pulmonary disease, and bilateral nonexudative age-related macular degeneration.Review of the care plan dated 03/20/23 revealed Resident #34 was at risk for falls due to advanced age, history of vertigo, atrial fibrillation, congestive heart failure, and spinal stenosis; incontinence of bowel and bladder, use of high fall risk medication, visual/auditory impairments, moderate cognitive impairment, required assistance for mobility/transfers and impulsive at times, and was at a high fall risk. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #34 had severe cognitive impairment. Review of the facility's incident/accident log revealed Resident #34 had a fall on 02/12/26.The fall investigation dated 02/12/26 revealed at 5:15 A.M., Resident #34 was found on floor lying supine next to bed, head toward foot of bed, with pillow under his head. Resident #34 was unable to explain how he ended up on the floor. Immediate intervention was Resident #34 was assessed by nurse, requiring assistance of two staff and Hoyer lift to bed. Follow up intervention was low bed. Resident #34 denied hitting head, and there was skin tear to his right elbow. The fall investigation was completed by Registered Nurse (RN) #100. The fall investigation did not note Resident #34 had a hematoma of the scalp and did not initiate neurological checks.Review of Physician Assistant (PA) #24's appointment note dated 02/12/26 revealed Resident #34's chief complaint/reason for visit was due to a fall. Resident #34 was noted with hematoma of scalp and was currently on anticoagulation. Resident #34's daughter declined an emergency room (ER) evaluation as does the resident. Physical exam notes right posterior scalp swelling, tenderness without laceration and musculoskeletal review revealed abrasion and bruise right posterior scapular spine. Assessment and plan notes scalp contusion status post mechanical fall noting neuro checks intact and remains on Plavix and Eliquis (anticoagulants).The skin assessment noted 02/12/26 at 6:34 P.M. completed by Licensed Practical Nurse (LPN) #111 revealed no new skin findings. The skin assessment did not identify Resident #34 had a hematoma of the scalp.The progress notes dated 02/14/26 revealed Resident #34 had complaints of head and neck pain. Administered Tylenol (treats mild pain) with positive results.The follow up appointment dated 02/19/26 with PA #245 revealed Resident #34's chief complaint/reason for visit was a headache status post fall. Resident #34 was seen for follow up after fall and hitting head on 02/12/26. Staff reported Resident #34 with intermittent headaches since Saturday (02/14/26). The headache was near the forehead. Tylenol has been effective when given. Resident #34 was currently on Plavix and Eliquis. PA #245 discussed with Resident #34 and he was adamant he does not want to go to the hospital. His power of attorney (POA) was present. Assessment and plan included acetaminophen 500 milligrams (mg) two tablets three times daily for 10 days, hold Eliquis for 10 days then resume, and remain on Plavix. PA #245 discussed with Resident #34 and POA that they cannot rule out acute brain bleed.Interview on 03/19/26 at 12:25 PM with RN #100 confirmed she did not know Resident #34 suffered a hematoma and headaches requiring the pause of his Eliquis and confirmed neurological checks were not initiated because she was told Resident #34 did not hit his head from Resident #34 or the staff.Review of the facility's policy titled Fall Prevention and Management revised on 01/28/25 revealed at the time of the fall, the nurse will complete a physical assessment to determine if any injury occurred, notify the physician and responsible party, (continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | implement an immediate intervention, if resident reports that they hit their head, there is evidence that they hit their head (bump, redness, hematoma, etc.) or it was witnessed they hit their head, or the fall is unwitnessed then neurological checks are to be documented initially and then every two hours for 24 hour on the neurological progress note. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, review of manufacturer instructions, and facility policy review, the facility failed to ensure their medication error was below five percent (%). There were three medication errors out of 33 opportunities resulting in a 9.09% medication error rate. This affected three residents (#11, #24. and #29) observed during medication administration. The facility census was 42.Findings include:1. Review of Resident #24's medical record revealed an admission date of 11/29/2023. Diagnoses included dementia and essential (primary) hypertension (HTN). The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #24 had severe cognitive impairment.The care plan dated 02/17/26 revealed Resident #24 was at risk for complications related to HTN. Interventions included to administer antihypertensive medications as ordered (see (medication administration record MAR)).Review of Resident #24's physician orders dated 01/07/26 revealed an order of Metoprolol Succinate (treats HTN) tablet Extended-Release 24-hour (hr), 25 milligrams (mg), administer 12.5 mg. There was no physician order the medication could be crushed. Observation on 03/17/26 at 8:58 A.M. revealed Registered Nurse (RN) #105 removed metoprolol medication card from the medication cart to administer it to Resident #24. The medication card for Metoprolol Succinate 25 mg extended release 24-hr, administer 12.5 mg half tablet stated do not crush or chew. RN #105 stated Resident #24 took pills crushed and metoprolol succinate extended release 24-hr was crushed and administered to Resident #24 in applesauce at 9:01 A.M. The MAR confirmed Resident #24 was administered Metoprolol Succinate tablet Extended-Release 24-hr, 25 mg, administer 12.5 mg on 03/17/26 by Registered Nurse (RN) #105.Interview on 03/17/26 at 9:34 A.M. with RN #105 confirmed she crushed Resident #24's Metoprolol Ssuccinate Extended-Release tablet and administered it to Resident #24.Interview on 03/18/26 at 11:10 A.M. with the Director of Nursing (DON) revealed there was a binder containing list of medications that should not be crushed available on each medication cart.Review of the Food and Drug Administration medication label for Metoprolol Succinate Extended-Release Tablets revised 05/2025 revealed Metoprolol Succinate extended-release tablets are scored and can be divided; however, do not crush or chew the whole or half tablet.2. Review of Resident #11's medical record revealed an admission date of 08/02/24. Diagnoses included gastro-esophageal reflux disease (GERD) without esophagitis.Review of Resident #11's physician orders dated 03/18/25 revealed an order for Pantoprazole tablet (treats GERD), delayed release (DR/EC) 20 milligrams (mg), administer 20 mg once a day. There was no physician order to crush the medication. The care plan dated 02/20/26 revealed Resident #11 has an esophageal disorder. An intervention included to administer medications and return to assess effectiveness.Review of Resident #11's Medication Administration Record (MAR) revealed Resident #11 was administered Pantoprazole on 03/18/26 by Registered Nurse (RN) #103.Observation on 03/18/26 at 8:10 A.M. revealed RN #103 removed Pantoprazole medication card from the medication cart to administer to Resident #11. The medication card for Pantoprazole DR 20 mg tablet stated do not crush or chew. Further observation revealed RN #103 crushed all medications (including Pantoprazole; except Mucinex DM) and administered the crushed medications to Resident #11 in applesauce.Interview on 03/18/26 at 8:18 A.M. with RN #103 confirmed she crushed the Pantoprazole sodium DR 20 mg tablet and administered to Resident #11.Review of the Food and Drug Administration medication label revised 12/2013 revealed the administration instructions stated patients should be cautioned that pantoprazole sodium delayed-release tablets should not be split, chewed, or crushed.3. Review of Resident #29's medical record revealed an admission date of 03/10/26. Diagnoses included type II diabetes with diabetic neuropathy.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 had impaired cognition and received four insulin injections during the review period. Review Resident #29's physician orders dated 03/10/26 revealed an order for Tresiba Flextouch U-200 (insulin degludec) insulin pen; 200 unit/millimeter (ml) (continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | (3.0 mL); amount 20 units; subcutaneous once a day early morning 6:00 A.M. to 10:00 A.M. There was an order for insulin lispro pen 100 unit/ ml; amount per sliding scale.The care plan dated 03/11/26 revealed Resident #29 was at risk for complications related to diabetes mellitus with neuropathy. Interventions included to administer medications as physician order.Observation on 03/19/26 at 7:25 A.M. of medication administration revealed Registered Nurse (RN) #116 did not prime Tresiba pen prior to administering 20 units of Tresiba to Resident #29's left arm.Interview on 03/19/26 at 7:34 A.M. with RN #116 confirmed RN #116 did not prime Tresiba pen prior to administering to Resident #29.Review of the Quick Start Guide and Instructions of Use (IFU) for Tresiba(R) U-100 and U-200 FlexTouch(R) pen revealed prime the pen by turning the dose selector to select two units. Press and hold the dose button until the dose counter shows zero. Make sure a drop appears.Review of the facility's policy titled Subcutaneous Insulin dated 01/2026 revealed after attaching a new needle and expose cap, prime the insulin pen noting priming the pen means removing the air from the needle and cartridge that may collect during normal use and ensures the pen is working correctly. Each click is one unit, dial the pen up to two unit, unless otherwise specified by manufacturer, point pen need toward the ceiling and gently tap the side, press the button on the bottom all the way in, you should see a drop of insulin come out, if you do not see the drop, repeat the priming process. |

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| | 366310 | A. Building<br>B. Wing | 03/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Ohio Living Sarah Moore | 26 North Union Street<br>Delaware, OH 43015 |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of manufacturer instructions, observation, staff interview, and facility policy review, the facility failed to ensure residents were free of significant medication errors when Resident #29's insulin pen was not primed prior to administration. This affected one (#29) of three residents reviewed for medication administration. The facility identified there were four residents receiving insulin. The facility census was 42.Findings include:Review of Resident #29's medical record revealed an admission date of 03/10/26. Diagnoses included type II diabetes with diabetic neuropathy.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 had impaired cognition and received four insulin injections during the review period. Review Resident #29's physician orders dated 03/10/26 revealed an order for Tresiba Flextouch U-200 (insulin degludec) insulin pen; 200 unit/millimeter (ml) (3.0 mL); amount 20 units; subcutaneous once a day early morning 6:00 A.M. to 10:00 A.M. There was an order for insulin lispro pen 100 unit/ ml; amount per sliding scale.The care plan dated 03/11/26 revealed Resident #29 was at risk for complications related to diabetes mellitus with neuropathy. Interventions included to administer medications as physician order.Observation on 03/19/26 at 7:25 A.M. of medication administration revealed Registered Nurse (RN) #116 did not prime Tresiba pen prior to administering 20 units of Tresiba to Resident #29's left arm.Interview on 03/19/26 at 7:34 A.M. with RN #116 confirmed RN #116 did not prime Tresiba pen prior to administering to Resident #29.Review of the Quick Start Guide and Instructions of Use (IFU) for Tresiba(R) U-100 and U-200 FlexTouch(R) pen revealed prime the pen by turning the dose selector to select two units. Press and hold the dose button until the dose counter shows zero. Make sure a drop appears.Review of the facility's policy titled Subcutaneous Insulin dated 01/2026 revealed after attaching a new needle and expose cap, prime the insulin pen noting priming the pen means removing the air from the needle and cartridge that may collect during normal use and ensures the pen is working correctly. Each click is one unit, dial the pen up to two unit, unless otherwise specified by manufacturer, point pen need toward the ceiling and gently tap the side, press the button on the bottom all the way in, you should see a drop of insulin come out, if you do not see the drop, repeat the priming process. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, policy review, and staff interviews, the facility failed to ensure staff utilized proper protective equipment (PPE) when providing direct care to Resident #8, failed to utilize a sterile technique for catheter care and store the catheter bag in a sanitary manner, and failed to perform proper hand hygiene after completing a blood glucose check for Resident #29. This affected two (Residents #8 and #29) of three residents reviewed for infection control. The facility census was 42.Findings include:1. Review of the medical record for Resident #8 revealed a re-entry date of 12/20/25. Diagnoses included obstructive reflux uropathy and retention of urine.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 had intact cognition. Resident #8 had an ileostomy (a surgically created opening (stoma) that brings the small intestine (ileum) to the abdominal surface, allowing waste to bypass the colon and drain into an external pouch) and had a suprapubic catheter (a tube inserted through a small, low-abdominal incision directly into the bladder to drain urine when the urethra cannot be used). Resident #8 was dependent on the staff for assistance with his ileostomy bag (stoma pouch) (a medical device worn over a surgically created opening (stoma) in the abdomen to collect waste).<br><br>Review of the care plan for Resident #8 revealed a focus of enhanced barrier precautions (EBP) will be maintained per facility/organization policy related to suprapubic catheter in place. Interventions included follow any signage posted, maintain all precautions during every episode of care, and use appropriate personal protective equipment (PPE) with every episode of care. PPE will be provided by the facility at the entrance room.<br><br>The care plan focus area was Resident #8 required indwelling catheter related to benign prostatic hyperplasia (BPH) with urinary retention and obstructive uropathy. Interventions included suprapubic catheter flush with 20 milliliters (ml) sterile water twice a day, avoid obstructions in the drainage, do not allow tubing or any part of the drainage system to touch the floor, keep catheter system a closed system as much as possible, and position bag below level of bladder and provide catheter care as ordered.<br><br>Review of a physician order dated 12/04/24 for Resident #8 revealed change colostomy bag every Monday, Wednesday, Friday and as needed. An order dated 03/06/25 for EBP related to suprapubic catheter in place every shift. An order dated 12/24/25 for suprapubic catheter flush with 30 ml sterile water every morning once a day.<br><br>Observation on 03/17/26 at 2:21 P.M. revealed Licensed Practical Nurse (LPN) #112 changed the ileostomy bag for Resident #8. LPN #112 was not wearing a gown during the ileostomy change. There was no signage for EBP on Resident #8's door and there was no PPE by the entrance to Resident #8's room. The PPE was found in Resident #8's bathroom.<br><br>Interview on 03/17/26 at 3:58 P.M. with LPN #112 verified she did not wear a gown to change Resident #8's ileostomy bag. LPN #112 verified there was no EBP sign in Resident #8's room. LPN #112 verified the EBP drawers with gowns and gloves were in Resident #8's bathroom and it was not visible for staff or visitors to know Resident #8 was on EBP.<br><br>Observation and interview on 03/18/26 at 8:18 A.M. revealed LPN #111 prepared a syringe for flushing the suprapubic catheter for Resident #8. LPN #111 did not use sterile technique to flush<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #8's suprapubic catheter. Resident #8's catheter bag was hanging on the edge of his trash can and above his bladder. LPN #111 verified Resident #8's catheter bag was hanging on trash can at the time of the observation.<br><br>Interview on 03/18/26 at 11:32 A.M. with LPN #111 stated a suprapubic flush was a clean procedure. LPN #111 verified she did not use the sterile technique to flush Resident #8's catheter. LPN #111 stated she did not have eye protection, did not wear sterile gloves or gown, did not use a sterile towel or sterile antiseptic to disconnect and flush the suprapubic catheter. LPN #111 stated she did not know where to look for facility resources to learn how to perform a procedure and stated the facility usually educated her on procedures.<br><br>Interview on 03/18/26 at 2:19 P.M. with the Director of Nursing (DON) stated the suprapubic catheter changes are a clean procedure. The DON stated she thought the suprapubic flushes were a clean procedure but learned today it was sterile procedure.<br><br>Review of the facility's policy titled Infection Control-Enhanced Barrier Precautions revised date of 01/07/26 revealed EBP will be followed for the illnesses specified by the Centers for Disease Control and Prevention (CDC).<br><br>The facility policy titled Infection Control-Enhanced Barrier Precautions revised date of 01/07/26 revealed staff should wear a gown during high-contact resident care dressing, bathing/shower, transferring, providing hygiene, changing linens, changing, briefs or assisting with toileting.<br><br>The facility policy titled Suprapubic Catheter Care dated 12/15/25 revealed care of an established suprapubic catheter site included daily cleaning. A nurse specially trained in sterile technique and suprapubic catheter care can perform either of these procedures. One who was specially trained in sterile technique and suprapubic catheter replacement can replace a suprapubic catheter if needed.<br><br>2. Observation on 03/19/26 at 7:25 A.M. revealed Registered Nurse (RN) #116 performed a blood glucose check on Resident #29. Then, RN #116 removed her gloves, gathered supplies, left Resident #29's room and did not perform hand hygiene. RN #116 placed the used glucometer on the top of the medication cart and used the computer and then obtained Resident #29's insulin pen from cart without performing hand hygiene.<br><br>Interview on 03/19/26 at 7:34 A.M. with RN #116 confirmed she did not perform hand hygiene after blood sugar check.<br><br>Review of the facility's policy titled Hand Hygiene, revised 09/15/25, revealed hand hygiene should be performed before direct contact, putting on gloves, or inserting an invasive device, and after removing gloves. The World Health Organization (WHO) recommends using either an alcohol-based hand rub soap and water preparing or handling medications.<br><br>Review of the facility's policy titled, Glucometer Cleaning, revised 01/07/26 revealed throughout the procedure, perform appropriate hand hygiene, perform hand hygiene immediately after removal of gloves and before touching other medical supplies intended for use on other persons. |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement a program that monitors antibiotic use.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, review of facility policy, and staff interviews, the facility failed to follow an antibiotic stewardship program to monitor antibiotic use for the residents. This affected three (#19, #23, and #25) of three residents reviewed for antibiotic stewardship. The facility census was 42.Findings include:1. Review of the medical record for Resident #19 revealed a re-entry date of 01/22/25 with diagnoses included hydrocephalus and presence of cerebrospinal fluid drainage device. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 had no cognitive impairment.<br><br>Review of the care plan for Resident #19 revealed a focus of on prophylactic antibiotics related to history of urinary tract infections.<br><br>Review of a physician order dated 11/02/24 revealed an order for Macrobid (antibiotic) capsule 100 milligrams (mg) oral once a day.<br><br>Review of the pharmacy recommendations dated 12/02/25 revealed Resident #19 had received Macrobid 100 mg every day since 11/02/24 for prophylaxis. Please evaluate continued antibiotic prophylaxis beyond six months. The physician response revealed Resident #19's Macrobid was managed by urologist for chronic suppressive therapy.<br><br>Review of the pharmacy recommendations dated 03/04/26 revealed Resident #19 has been on Macrobid 100 mg oral daily prophylactically since 11/02/24. Please consider discontinuation. The physician response revealed urology follows, no change advised.<br><br>Interview on 03/18/26 at 11:53 A.M. with the Director of Nursing (DON) stated she was unable to locate any urology notes and spoke to Resident #19 and spouse who stated Resident #19 had not seen a urologist in at least two years. The DON stated per Resident #19's spouse, Resident #19 had several urinary tract infections years ago and her primary care physician at the time started her on Macrobid. At 12:12 P.M., the DON stated Resident #19's last urinary tract infection was when she admitted to the facility in 09/2024.<br><br>2. Review of the medical for Resident #25 revealed an admission date of 01/12/26. Diagnoses included urinary tract infection (UTI). The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #25 had severe cognitive impairment and required moderate staff assistance for toileting hygiene.<br><br>Review of the care plan revealed Resident #25 required a suprapubic catheter related to obstructive and reflux uropathy with a diagnosis of benign prostatic hyperplasia (BPH) with lower UTI. Interventions included to avoid obstructions in the drainage, do not allow tubing or any pat of the drainage system to touch the floor, keep catheter system a closed system as much as possible, position bag below the level of bladder, and report signs/symptoms of UTI (acute confusion, urgency, frequency, bladder spasms, nocturia, burning pain, difficulty urinating, low back/flank pain, malaise, nauseas/vomiting, chills, fever, foul odor, concentrated urine, blood in urine).<br><br>Review of Resident #25's progress notes dated 02/15/26 to 03/03/26 revealed suprapubic catheter was patent, and draining amber colored urine. Resident #25 had at least three falls within a week with some confusion.<br>(continued on next page) |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Medication Administration Record (MAR) dated 03/2026 revealed an order dated 03/03/26 for urinalysis (UA) and culture and Sensitivity (C&S) which was collected on 03/05/26.<br><br>Review of the urine final lab results dated 03/09/26 revealed greater than 100,000 colonies/milliliter (ml) coagulase negative for staphylococci, not saprophyticus, 10,000 to 50,000 colonies/ml candida albicans, and 10,000 to 50,000 colonies ml corynebacterium.<br><br>The physician order dated 03/10/26 to 03/17/26 revealed an order for Macrobid (antibiotic) capsule 100 milligrams (mg) give one tablet two times a day for seven days for UTI.<br><br>Review of the Infection Tracker with McGeer's Criteria Version with an event date 03/10/26 and completion date 03/18/26 revealed no criteria was checked for Resident #14, indicating the resident did not meet the McGeer's criteria.<br><br>Review of Resident #25's MAR revealed his suprapubic catheter was changed on 03/13/26.<br><br>Interview on 03/18/26 at 11:53 A.M. with the DON who stated there were no urology notes for Resident #25, so she called and spoke with Resident #25's daughter who stated Resident #14 had not been to a urologist since probably 2024. The DON stated Resident #25's suprapubic catheter was changed in the facility. At 2:19 P.M., the DON stated McGeer's criteria number two stated if the current catheter had been changed greater than 14 days, than Resident #14 did not meet McGeer's criteria for an antibiotic according to the form completed.<br><br>3. Review of the medical record for Resident #23 revealed an admission date of 01/13/26. Diagnoses included obstructive and reflux uropathy, benign prostatic hyperplasia with lower urinary tract symptoms with obstruction and retention, overactive bladder, hematuria, chronic indwelling catheter, and infection and inflammatory reaction due to an indwelling urethral catheter.<br><br>The admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #23 was cognitively intact, required substantial or maximal assistance from staff with toileting, had a catheter, and was currently receiving an antibiotic.<br><br>Review of the hospital record dated 03/14/26 revealed a urinalysis showing amber cloudy urine with a specific gravity of 1.012 and a pH of 6.0. Results included protein negative, glucose negative, bilirubin negative, urobilinogen less than 2.0, blood large, nitrite negative, leukocyte esterase large, white blood cells greater than 180, red blood cells greater than 180, and no bacteria seen. The hospital record also documented diagnoses of hematuria and acute urinary tract infection (UTI).<br><br>Review of the after visit summary dated 03/14/26 revealed a new order for cephalexin (antibiotic) 500 milligrams (mg) one capsule by mouth four times a day for five days.<br><br>The physician order dated 03/15/26 revealed cephalexin 500 mg four times a day for five days.<br><br>Review of the medication administration record revealed Resident #23 received the initial dose on 03/15/26 at 9:00 A.M. and continued scheduled doses at 1:00 P.M. 5:00 P.M. and 9:00 P.M. The resident received all doses up until 03/19/26 at 9:00 A.M. when the order was discontinued.<br><br>Review of the infection report dated 03/19/26 revealed Resident #23 had a documented diagnosis of a UTI identified as a healthˆcare associated infection. The resident did not exhibit any of the required<br>(continued on next page) |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | clinical signs for a UTI including fever or hypotension, acute mental status change with leukocytosis, new suprapubic or flank pain, or purulent drainage or genital tenderness. Documentation showed the resident had bloody urine in the emergency room and the hospital ordered an antibiotic that was not necessary.<br><br>Interview on 03/19/26 at 8:54 A.M. with the Director of Nursing (DON) confirmed the hospital urinalysis from 03/14/26 indicated the resident did not have a UTI and that the antibiotic ordered at hospital discharge was unnecessary. The DON reported she had not reviewed the hospital record and typically continues hospital ordered antibiotics without confirming if they were appropriately ordered. At 9:55 A.M., the DON revealed the physician was notified and the antibiotic was discontinued.<br><br>Review of the facility policy titled Infection Definitions: Antibiotic Stewardship revised date of 01/07/26 revealed antibiotic treatment will only be considered if the suspected infection meets the McGeer (standardized surveillance definitions used to identify infections in long-term care facilities, such as nursing homes) definitions of and the pathology is strongly suggesting that an infection is of a bacterial nature. Urinary tract infections in a resident with a catheter at least one of the following sub criteria fever, rigors or new onset hypotension, with no alternate site of infection, either acute change in mental status or acute functional decline, with no literate site of infection, new onset suprapubic pain or flank pain or tenderness, purulent drainage from around the catheter or acute pain, swelling or tenderness of the testes, epididymis or prostate and must have urinary catheter specimen culture with at least 100,000 colony |

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| F 0814<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Dispose of garbage and refuse properly.<br><br>Based on observation and staff interview, the facility failed to ensure trash and recycling was properly contained in the dumpsters. This had the potential to affect all 42 residents residing in the facility.Findings include:Observation of the dumpster area on 03/16/26 at 1:42 P.M. and 2:40 P.M. revealed multiple unbroken cardboard boxes scattered around the air conditioning units. Approximately 20 wet boxes that were not broken down were sitting on the ground next to the dumpster area. Wind had spread some of the boxes across the parking lot, and several were positioned against the chain link fence in the parking lot area. Trash had also accumulated near the air conditioning units on the opposite side of the stairs from the dumpsters. The trash included latex gloves and multiple pieces of unknown debris.Interview on 03/16/26 at 2:40 P.M. with [NAME] #155, confirmed the observations of unbroken cardboard boxes and trash accumulation in the dumpster area.Interview on 03/17/26 at 2:51 P.M. with the Administrator stated the facility did not have a recycling dumpster at this time. He stated staff had been placing boxes on the ground outside the dumpster area. He stated some trash near the air conditioning units was blown in from the community, staff were responsible for picking up any debris that blew up to the building. |