

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366325	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER Ohio Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE 3416 Columbus Ave Sandusky, OH 44870	

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)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, review of a Self-Reported Incident (SRI), review of a facility investigation, review of staff witness statements, staff interview, and policy review, the facility failed to implement their abuse policy to provide timely interventions and further failed to provide notification to the appropriate medical and support staff for follow-up services. This affected one (#193) of eight residents reviewed for abuse and had the potential to affect all 25 residents on the Unit 3 South. The facility census was 242. Findings include: Review of the medical record for Resident #193 revealed an admission date of 08/29/24. Diagnoses included Alzheimer's disease, dementia, anxiety, hypertension, and dysphagia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment. Review of a facility Self-Reported Incident (SRI) dated 01/27/26 revealed staff reported an allegation of staff to resident verbal abuse for Resident #193. Review of a follow-up investigation report revealed staff witnessed Certified Nursing Assistant (CNA) #400 speaking inappropriately to Resident #193. CNA #400 was removed from duty and placed on administrative leave. The facility substantiated the allegation of verbal abuse. Also, the facility implemented an intervention for psychiatric services but there was no documentation the facility had timely contacted psychiatric services for resident care follow-up. Review of a nurse's note dated 01/27/26 at 5:45 P.M. revealed Resident #193's family was notified of a verbal abuse allegation. Further review of the nurse's notes from 01/27/26 through 01/30/26 revealed no documentation of notification to the physician, and no follow-up with the social worker. Further review of the progress notes from 01/27/26 through 02/04/26 revealed no documentation psychiatric services was notified and no documentation the resident was seen by psychiatric services after the alleged abuse. Interview on 02/04/26 at 1:46 P.M., the Director of Nursing (DON) revealed staff should have followed up with necessary notifications and assessments for the residents with allegations of abuse. Interview on 02/05/26 at 8:16 A.M., Licensed Social Worker (LSW) #312 revealed she was not made aware of the allegation of verbal abuse toward Resident #97 until yesterday. LSW #312 revealed the facility was supposed to notify her of allegations of abuse. LSW #312 also revealed psychiatric services should be notified quickly to follow up with residents with allegations of abuse. Interview on 02/05/26 at 9:30 A.M., the Assistant Director of Nursing (ADON) #370 revealed whoever was covering the unit at the time of the allegation should have notified social services, the physician, and the psychiatric services provider. ADON #370 verified the psychiatric services provider was not notified until several days later. Review of the facility policy Reporting Allegation of Abuse/Neglect/Exploitation, dated 03/25/25 revealed the facility the facility would provide complete and thorough documentation of the investigation. Further review of the policy revealed the facility would respond to the residents' needs and protect from further incidents. The facility would notify the physician and resident's family/legal representative. Also, the facility would monitor and document the resident's condition, including response to medical treatment</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 366325	If continuation sheet Page 1 of 12

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>or nursing interventions and document actions taken in the medical record. Review of the facility policy Abuse, Neglect, Exploitation, dated 03/25/25 revealed the facility would immediately protect the alleged victim and integrity of the investigation. The facility would examine the alleged victim for any sign of injury, including a physician examination or psychosocial assessment if needed, provide emotional support and counseling to the resident during and after the investigation as needed. This deficiency represents non-compliance investigated under Complaint Number 2731992.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, review of a Self-Reported Incident (SRI), review of a facility investigation, review of staff witness statements, staff interview, and policy review, the facility failed to report allegations of staff to resident abuse. This affected six (#244, #93, #243, #129, #193, #6) of eight residents reviewed for abuse and had the potential to affect all 25 residents on the Unit 3 South. The facility census was 242. Findings include:1. Review of the medical record for Resident #193 revealed an admission date of 08/29/24. Diagnoses included Alzheimer's disease, dementia, anxiety, hypertension, and dysphagia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment. Review of a facility Self-Reported Incident (SRI) dated 01/27/26 revealed staff reported an allegation of staff to resident verbal abuse for Resident #193. Review of a follow-up investigation report revealed staff witnessed Certified Nursing Assistant (CNA) #400 speaking inappropriately to Resident #193. CNA #400 was removed from duty and placed on administrative leave. The facility substantiated the allegation of verbal abuse. Further review of the investigation report revealed the facility had not interviewed all staff present in the dining room during lunch at the time of the allegation of verbal abuse. Further review of the staff witness statements revealed staff had reported additional allegations of resident abuse against CNA #400 with no documentation of an investigation and no Self-Reported Incidents submitted to the state agency regarding the allegations. Review of a nurse's note dated 01/27/26 at 5:45 P.M. revealed Resident #193's family was notified of a verbal abuse allegation. Further review of the nurses' notes from 01/17/26 through 01/30/26 revealed no documentation of notification to the physician, and no follow-up with the social worker. Also, the facility implemented an intervention for a psychiatric consult but there was no documentation the facility had contacted psychiatric services for resident follow-up.2. Review of the closed medical record for Resident #244 revealed an admission date of 04/16/25 and a discharge date of 01/23/26. Diagnoses included dementia, type two diabetes mellitus, and aphasia.Review of the quarterly MDS dated [DATE] revealed the resident required substantial/maximal assistance for eating. Review of the nurse's notes dated 01/01/26 through 02/03/26 for Resident #244 revealed no documentation of the allegation of abuse. Review of the facility SRIs also revealed no reported allegations of physical abuse by staff for Resident #244.3. Review of the closed medical record for Resident #243 revealed an admission date of 08/01/23 and a discharge date of 01/27/26. Diagnoses include Alzheimer's disease, Parkinson's disease, dementia, aphasia, and dysphagia oral phase.Review of the significant change MDS dated [DATE] revealed Resident #243 had severe cognitive impairment. The resident was dependent on staff for meal assistance. Review of the nurse's notes dated 01/01/26 through 02/03/26 for Resident #243 revealed no documentation of alleged staff to resident abuse. Review of the facility SRIs revealed no reported allegations of abuse by staff for Resident #243. 4. Review of the medical record for Resident #93 revealed an admission date of 09/05/18. Diagnoses included hemiplegia and hemiparesis, dementia, type two diabetes mellitus, and dysphagia.Review of the quarterly MDS assessment dated [DATE] revealed the resident had severe cognitive impairment. The resident was dependent on staff for feeding assistance. Review of the nurse's notes from 01/01/26 through 02/03/26 for Resident #93 revealed no documentation of allegations of abuse. Review of the facility SRIs revealed no allegations of staff to resident abuse had been submitted for Resident #93. 5. Review of the medical record for Resident #129 revealed an admission date of 04/07/25. Diagnoses include Alzheimer's disease, dementia, and hypertension. Review of the quarterly MDS assessment dated [DATE] revealed the resident required set-up assistance for meals.Review of the nurse's notes</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>dated 01/01/26 through 02/03/26 for Resident #129 revealed no documentation of an abuse allegation. Review of the facility SRIs revealed no SRIs submitted for staff to resident abuse for Resident #129.6. Review of the medical record for Resident #6 revealed an admission date of 12/04/12. Diagnoses included Alzheimer's disease, dementia, osteoarthritis, and hypertension. Review of the quarterly MDS assessment dated [DATE] revealed Resident #6 had severe cognitive impairment. Review of the nurse's notes dated 01/01/26 through 02/03/26 for Resident #6 revealed no documentation of allegations of abuse. Review of the facility SRIs also revealed no reported allegations of staff to resident abuse for Resident #6. Review of a witness statement dated 01/28/26 by CNA #350 revealed on 01/27/26 Resident #193 was sleeping during lunch and CNA #400 went up to him and was yelling in his ear to keep waking him up to eat. CNA #350 noted CNA #400 was cursing in the dining room and yelling at the residents to wake up and eat. CNA #350 noted CNA #400 was not compliant with the resident's diet orders and it was not unusual for her to force feed the residents. There was no documentation CNA #350 was further questioned regarding the allegation of CNA #400 force feeding residents. Review of a witness statement dated 01/28/26 by CNA #374 revealed he responded yes when asked if he had witnessed any resident being mistreated or abused. CNA #374 revealed CNA #400 had yelled at Resident #6 and had force fed Resident #243. CNA #374 revealed the incidents were reported to the Assistant Director of Nursing (ADON) #370 and the Director of Nursing (DON). There was no documentation CNA #374 was further interviewed regarding the additional abuse allegations. Review of an undated witness statement by Dietary Staff (DS) #367 revealed on 01/27/26 CNA #400 was cursing at lunch and cursed at Resident #193 who was sleeping to wake up and eat. DS #367 revealed this had been going on for weeks/months. DS #367 revealed she had made reports of her yelling at the residents. DS #367 noted CNA #400 was mean to the residents. There was no documentation DS #367 was asked additional questions regarding her previous reports of CNA #400's treatment of residents. Review of a witness statement dated 01/28/26 by Speech Therapist (ST) #324 revealed at the lunch meal on 01/27/26 CNA #400 was opening swearing at other staff members regarding personal frustration or for being suggested to follow specific diet orders/recommendations. Review of a witness statement dated 01/29/26 by CNA #400 revealed she had denied verbally abusing Resident #193. There was no documentation CNA #400 was questioned regarding the additional allegations of abuse for Resident #243, Resident #244, Resident #93, Resident #193 and Resident #6. Interview on 02/03/26 at 10:07 A.M., LPN #488 revealed he had not witnessed resident abuse and had no reports of resident abuse from staff. Interview on 02/03/26 at 3:12 P.M., Certified Nursing Assistant (CNA) #350 revealed CNA #400 was cursing in the dining room. CNA #350 revealed CNA #400 would yell at residents to eat, and had force fed Resident #129 and Resident #193. CNA #350 revealed CNA #400 would put a spoon to Resident #193's mouth and the resident shook his head no. CNA #350 revealed CNA #400 then forced the spoon inside the resident's mouth. CNA #350 also revealed CNA #400 had forced a spoon into the mouth of Resident #129. CNA #350 also reported CNA #400 would awaken former Resident #244 and Resident #93 during meal service with sternal rubs. CNA #350 revealed she told CNA #400 to stop her actions but it went in one ear and out the other. CNA #350 revealed the incidents were reported to LPN #488 and LPN #402. Interview on 02/03/26 at 3:31 P.M., CNA #374 revealed he had witnessed CNA #400 and Resident #6 yelling at each other outside the dining room. CNA #374 also revealed he saw CNA #400 force fed former Resident #243 by literally forcing the food in the resident's mouth. CNA #374 revealed he had reported the incidents to LPN #302 who then reported the incident to ADON #370. Interview on 02/03/26 at 3:50 P.M., LPN #302 revealed CNA #374 had never reported CNA #400 force feeding a resident or yelling at a resident. LPN #302 revealed she had not witnessed any resident abuse during the lunch meal on 01/27/26. LPN #302 revealed force feeding a resident was</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>abusive and she would have immediately reported the abuse. Interview on 02/04/26 at 8:15 A.M., LPN #402 revealed he had never witnessed CNA #400 force feeding residents or performing sternal rubs on a resident. LPN #402 also revealed no staff had reported these allegations of abuse as they would have been immediately reported to a supervisor. Interview on 02/04/26 at 9:28 A.M., Supervisor RN #340 revealed anything significant from interviews conducted during an abuse investigation would be added to the summary report. RN #340 revealed the investigations were a team effort ultimately reviewed by the DON and the Administrator. RN #340 revealed he had interviewed CNA #374. RN #340 revealed CNA #374 had a meeting with the DON and had reported his concerns to her. RN #340 revealed the DON called me and told me to interview additional staff. RN #340 was not aware of any Self-Reported Incident or investigation for CNA #374's allegations. RN #340 revealed force feeding would be considered abusive. RN #340 revealed he could not recall staff reporting a nursing assistant completing a sternal rub. RN #340 revealed he had limited involvement in the investigation and was not familiar with CNA #400 or the involved residents. Interview on 02/04/26 at 9:54 A.M., Registered Nurse (RN) #342 revealed DS #367 had reported CNA #400 was at the meal service window cursing and had done so frequently. RN #342 revealed she asked ST #324 and CNA #400 to write statements. RN #342 revealed she notified the Director of Nursing and the Administrator. RN #342 revealed she was instructed to remove CNA #400 from the floor and begin an investigation. RN #342 revealed she spoke with Resident #193 who could not recall the incident. RN #342 revealed the residents on the unit were interviewed and skin sweeps were completed on the residents who could not be interviewed. RN #342 revealed the staff working the unit were asked to write statements. RN #342 revealed she was unaware the dietician was present on the unit during the meal service. RN #342 revealed the information for the investigation was gathered and the Administrator and DON completed the final review. RN #342 revealed force feeding a resident would be considered abuse and should be reported. RN #342 revealed she was not made aware of an allegation of CNA #400 waking up residents with a sternal rub which should not be completed by a nursing assistant. Interview on 02/04/26 at 11:05 A.M., Dietary Staff (DS) #367 revealed on 01/27/26 as staff were serving the lunch meal, CNA #400 was cursing at other staff and then went up Resident #193 and cursed at him to wake up. DS #367 revealed ST #324 told her they needed to do something about this and ST #324 needed her to back him up on this. DS #367 revealed the incident was reported to the head nurse. DS #367 revealed a couple months earlier that CNA #400 had yelled at a resident to sit down and shut up and had also yelled at another resident to get their head off of the table. DS #367 revealed she had reported the incidents to the nursing supervisor RN #602. DS #367 revealed she had discussed one incident in person with RN #602 and another incident over the phone with RN #602. DS #367 revealed she had not been asked to write a statement regarding the prior incidents. Interview on 02/04/26 at 1:46 P.M., the DON revealed the Administrator, and the DON should be notified when additional allegations of abuse were discovered during an abuse investigation. The DON revealed the nursing supervisors should be reviewing witness statements and additional allegations should be reported and additional investigations added. The DON revealed she had not reviewed the staff witness statements. The DON revealed she had not been notified of staff force feeding a resident. The DON verified the facility had not completed Self-Reported Incidents (SRI) for the additional allegations brought forward during the investigation of verbal abuse on 01/27/26. The DON revealed CNA #374 had talked to her on 01/30/26 and had never mentioned any abuse concerns during the two times she spoke with him. The DON also revealed staff should have followed up with necessary notifications and assessments for the residents with allegations of abuse. Interview on 02/04/26 at 2:39 P.M., RN #602 revealed he was aware of the allegation of CNA #400 force feeding residents. RN #602 revealed he had not</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>reported the allegation as CNA #400 was already off from work on administrative leave. RN #602 revealed he should have reported the allegation as force feeding would be considered abusive. RN #602 revealed he could not recall if DS #367 had reported allegations of resident mistreatment by CNA #400 in the past. Interview on 02/04/26 at 4:15 P.M., Dietary Supervisor (DS) #610 revealed DS #367 had concerns regarding how a nursing assistant was treating the residents. DS #610 revealed he dialed RN #602's number for DS #367 to speak with RN #602. DS #610 revealed he heard DS #367 reporting to RN #602 about a nursing assistant being mean to the residents. Interview on 02/05/26 at 8:16 A.M., Licensed Social Worker (LSW) #312 revealed she was not made aware of the allegation of verbal abuse toward Resident #97 until yesterday. LSW #312 revealed the facility was supposed to notify her of allegations of abuse. LSW #312 also revealed psychiatric services should be notified quickly to follow up with residents with allegations of abuse. Interview on 02/05/26 at 9:30 A.M., the Assistant Director of Nursing (ADON) #370 revealed whoever was covering the unit at the time of the allegation should have notified social services, the physician, and the psychiatric services provider. ADON #370 verified the psychiatric services provider was not notified until several days later. Further interview with ADON #370 revealed she was aware of an allegation of former Resident #243 being force fed but she had talked to the resident's wife who said the resident had not been force fed. ADON #370 verified the allegation was not reported or further investigated. Review of the facility policy Reporting Allegation of Abuse/Neglect/Exploitation, dated 03/25/25 revealed the facility would investigate all allegation of alleged violations by identifying and interviewing all involved person, including the alleged victim, alleged perpetrator, witnessed, and others who might have knowledge of the allegations. The facility would provide complete thorough documentation of the investigation. Further review of the policy revealed the facility would respond to the residents' needs and protect from further incidents, remove the accused, notify the Administrator, notify the facility police department, notify the physician and resident's family/legal representative. Also, the facility would monitor and document the resident's condition, including response to medical treatment or nursing interventions and document actions taken in the medical record. Review of the facility policy Abuse, Neglect, Exploitation, dated 03/25/25 revealed all alleged violations of any form of abuse would be reported immediately, but no later than two hours after the allegation was made if the events cause the involve abuse or serious bodily injury. The Administrator would report allegations or suspected abuse to the state survey agency and other officials in accordance with state law. Only the Administrator in consultation with the Superintendent and Chief Compliance Office can determine if abuse occurred. The facility would immediately protect the alleged victim and integrity of the investigation. The facility would examine the alleged victim for any sign of injury, including a physician examination or psychosocial assessment if needed, provide emotional support and counseling to the resident during and after the investigation as needed. This deficiency represents non-compliance investigated under Complaint Number 2731992.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the medical record, review of a Self-Reported Incident (SRI), review of a facility investigation, review of staff witness statements, staff interview, and policy review, the facility failed to thoroughly investigate allegations of staff to resident abuse. This affected six (#244, #93, #243, #129, #193, #6) of eight residents reviewed for abuse and had the potential to affect all 25 residents on the Unit 3 South. The facility census was 242. Findings include:1. Review of the medical record for Resident #193 revealed an admission date of 08/29/24. Diagnoses included Alzheimer's disease, dementia, anxiety, hypertension, and dysphagia.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment. Review of a facility Self-Reported Incident (SRI) dated 01/27/26 revealed staff reported an allegation of staff to resident verbal abuse for Resident #193. Review of a follow-up investigation report revealed staff witnessed Certified Nursing Assistant (CNA) #400 speaking inappropriately to Resident #193. CNA #400 was removed from duty and placed on administrative leave. The facility substantiated the allegation of verbal abuse. Further review of the investigation report revealed the facility had not interviewed all staff present in the dining room during lunch at the time of the allegation of verbal abuse. Further review of the staff witness statements revealed staff had reported additional allegations of resident abuse against CNA #400 with no documentation of an investigation and no Self-Reported Incidents submitted to the state agency regarding the allegations. Review of a nurse's note dated 01/27/26 at 5:45 P.M. revealed Resident #193's family was notified of a verbal abuse allegation. Further review of the nurse's notes from 01/17/26 through 01/30/26 revealed no documentation of notification to the physician, and no follow-up with the social worker. Also, the facility implemented an intervention for a psychiatric consult but there was no documentation the facility had contacted psychiatric services for resident follow-up.2. Review of the closed medical record for Resident #244 revealed an admission date of 04/16/25 and a discharge date of 01/23/26. Diagnoses included dementia, type two diabetes mellitus, and aphasia. Review of the quarterly MDS dated [DATE] revealed the resident required substantial/maximal assistance for eating.Review of the nurse's notes dated 01/01/26 through 02/03/26 for Resident #244 revealed no documentation of the allegation of abuse.Review of the facility SRIs also revealed no reported allegations of physical abuse by staff for Resident #244.3. Review of the closed medical record for Resident #243 revealed an admission date of 08/01/23 and a discharge date of 01/27/26. Diagnoses include Alzheimer's disease, Parkinson's disease, dementia, aphasia, and dysphagia oral phase.Review of the significant change MDS dated [DATE] revealed Resident #243 had severe cognitive impairment. The resident was dependent on staff for meal assistance. Review of the nurse's notes dated 01/01/26 through 02/03/26 for Resident #243 revealed no documentation of alleged staff to resident abuse. Review of the facility SRIs revealed no reported allegations of abuse by staff for Resident #243. 4. Review of the medical record for Resident #93 revealed an admission date of 09/05/18. Diagnoses included hemiplegia and hemiparesis, dementia, type two diabetes mellitus, and dysphagia.Review of the quarterly MDS assessment dated [DATE] revealed the resident had severe cognitive impairment. The resident was dependent on staff for feeding assistance. Review of the nurse's notes from 01/01/26 through 02/03/26 for Resident #93 revealed no documentation of allegations of abuse. Review of the facility SRIs revealed no allegations of staff to resident abuse had been submitted for Resident #93. 5. Review of the medical record for Resident #129 revealed an admission date of 04/07/25. Diagnoses include Alzheimer's disease, dementia, and hypertension. Review of the quarterly MDS assessment dated [DATE] revealed the resident required set-up assistance for meals. Review of the nurse's notes dated 01/01/26 through 02/03/26 for</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #129 revealed no documentation of an abuse allegation. Review of the facility SRIs revealed no SRIs submitted for staff to resident abuse for Resident #129.6. Review of the medical record for Resident #6 revealed an admission date of 12/04/12. Diagnoses included Alzheimer's disease, dementia, osteoarthritis, and hypertension. Review of the quarterly MDS assessment dated [DATE] revealed Resident #6 had severe cognitive impairment. Review of the nurse's notes dated 01/01/26 through 02/03/26 for Resident #6 revealed no documentation of allegations of abuse. Review of the facility SRIs also revealed no reported allegations of staff to resident abuse for Resident #6. Review of a witness statement dated 01/28/26 by CNA #350 revealed on 01/27/26 Resident #193 was sleeping during lunch and CNA #400 went up to him and was yelling in his ear to keep waking him up to eat. CNA #350 noted CNA #400 was cursing in the dining room, and yelling at the residents to wake up and eat. CNA #350 noted CNA #400 was not compliant with the resident's diet orders and it was not unusual for her to force feed the residents. There was no documentation CNA #350 was further questioned regarding the allegation of CNA #400 force feeding residents. Review of a witness statement dated 01/28/26 by CNA #374 revealed he responded yes when asked if he had witnessed any resident being mistreated or abused. CNA #374 revealed CNA #400 had yelled at Resident #6 and had force fed Resident #243. CNA #374 revealed the incidents were reported to the Assistant Director of Nursing (ADON) #370 and the Director of Nursing (DON). There was no documentation CNA #374 was further interviewed regarding the additional abuse allegations. Review of an undated witness statement by Dietary Staff (DS) #367 revealed on 01/27/26 CNA #400 was cursing at lunch and cursed at Resident #193 who was sleeping to wake up and eat. DS #367 revealed this had been going on for weeks/months. DS #367 revealed she had made reports of her yelling at the residents. DS #367 noted CNA #400 was mean to the residents. There was no documentation DS #367 was asked additional questions regarding her previous reports of CNA #400's treatment of residents. Review of a witness statement dated 01/28/26 by Speech Therapist (ST) #324 revealed at the lunch meal on 01/27/26 CNA #400 was opening swearing at other staff members regarding personal frustration or for being suggested to follow specific diet orders/recommendations. Review of a witness statement dated 01/29/26 by CNA #400 revealed she had denied verbally abusing Resident #193. There was no documentation CNA #400 was questioned regarding the additional allegations of abuse for Resident #243, Resident #244, Resident #93, Resident #193 and Resident #6. Further review of the witness statements revealed no documentation of a witness statement by Registered Dietitian (RD) #318. Observation on 02/03/26 at 11:27 A.M. with the DON and Police Chief (PC) #648 of video surveillance dated 01/27/26 during the lunch meal on Unit 3 South from 12:20 P.M. through 1:08 P.M. revealed residents were in the dining room with staff serving and assisting the residents with meals. Staff present during the meal service in the dining room identified by PC #648 and the DON included CNA #400, CNA #350, CNA #330, Licensed Practical Nurse (LPN) #302, ST #324, RD #318, CNA #308, and DS #367. The DON verified RD #318 had not been interviewed regarding the incident. Further observations of the video surveillance revealed CNA #400 sat down briefly by Resident #193 during the meal. The surveillance video contained no audio and it could not be determined if CNA #400 was cursing or yelling at Resident #193. Interview on 02/03/26 at 10:07 A.M., LPN #488 revealed he had not witnessed resident abuse and had no reports of resident abuse from staff. Interview on 02/03/26 at 3:12 P.M., CNA #350 revealed CNA #400 was cursing in the dining room. CNA #350 revealed CNA #400 would yell at residents to eat, and had force fed Resident #129 and Resident #193. CNA #350 revealed CNA #400 would put a spoon to Resident #193's mouth and the resident shook his head no. CNA #350 revealed CNA #400 then forced the spoon inside the resident's mouth. CNA #350 also revealed CNA #400 had forced a spoon into the mouth of Resident #129. CNA #350 also reported CNA #400 would awaken former Resident #244 and</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Ohio Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE 3416 Columbus Ave Sandusky, OH 44870	
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #93 during meal service with sternal rubs. CNA #350 revealed she told CNA #400 to stop her actions but it went in one ear and out the other. CNA #350 revealed the incidents were reported to LPN #488 and LPN #402. Interview on 02/03/26 at 3:31 P.M., CNA #374 revealed he had witnessed CNA #400 and Resident #6 yelling at each other outside the dining room. CNA #374 also revealed he saw CNA #400 force fed former Resident #243 by literally forcing the food in the resident's mouth. CNA #374 revealed he had reported the incidents to LPN #302 who then reported the incident to ADON #370. Interview on 02/03/26 at 3:50 P.M., LPN #302 revealed CNA #374 had never reported CNA #400 force feeding a resident or yelling at a resident. LPN #302 revealed she had not witnessed any resident abuse during the lunch meal on 01/27/26. LPN #302 revealed force feeding a resident was abusive and she would have immediately reported the abuse. Interview on 02/04/26 at 8:15 A.M., LPN #402 revealed he had never witnessed CNA #400 force feeding residents or performing sternal rubs on a resident. LPN #402 also revealed no staff had reported these allegations of abuse as they would have been immediately reported to a supervisor. Interview on 02/04/26 at 9:28 A.M., Supervisor RN #340 revealed anything significant from interviews conducted during an abuse investigation would be added to the summary report. RN #340 revealed the investigations were a team effort ultimately reviewed by the DON and the Administrator. RN #340 revealed he had interviewed CNA #374. RN #340 revealed CNA #374 had a meeting with the DON and had reported his concerns to her. RN #340 revealed the DON called me and told me to interview additional staff. RN #340 was not aware of any Self-Reported Incident or investigation for CNA #374's allegations. RN #340 revealed force feeding would be considered abusive. RN #340 revealed he could not recall staff reporting a nursing assistant completing a sternal rub. RN #340 revealed he had limited involvement in the investigation and was not familiar with CNA #400 or the involved residents. Interview on 02/04/26 at 9:54 A.M., Registered Nurse (RN) #342 revealed DS #367 had reported CNA #400 was at the meal service window cursing and had done so frequently. RN #342 revealed she asked ST #324 and CNA #400 to write statements. RN #342 revealed she notified the Director of Nursing and the Administrator. RN #342 revealed she was instructed to remove CNA #400 from the floor and begin an investigation. RN #342 revealed she spoke with Resident #193 who could not recall the incident. RN #342 revealed the residents on the unit were interviewed and skin sweeps were completed on the residents who could not be interviewed. RN #342 revealed the staff working the unit were asked to write statements. RN #342 revealed she was unaware the dietician was present on the unit during the meal service. RN #342 revealed the information for the investigation was gathered and the Administrator and DON completed the final review. RN #342 revealed force feeding a resident would be considered abuse and should be reported. RN #342 revealed she was not made aware of an allegation of CNA #400 waking up residents with a sternal rub which should not be completed by a nursing assistant. Interview on 02/04/26 at 11:05 A.M., DS #367 revealed on 01/27/26 as staff were serving the lunch meal, CNA #400 was cursing at other staff and then went up Resident #193 and cursed at him to wake up. DS #367 revealed ST #324 told her they needed to do something about this and ST #324 needed her to back him up on this. DS #367 revealed the incident was reported to the head nurse. DS #367 revealed a couple months earlier CNA #400 had yelled at a resident to sit down and shut up, and had also yelled at another resident to get their head off of the table. DS #367 revealed she had reported the incidents to the nursing supervisor RN #602. DS #367 revealed she had discussed one incident in person with RN #602 and another incident over the phone with RN #602. DS #367 revealed she had not been asked to write a statement regarding the prior incidents. Interview on 02/04/26 at 1:46 P.M., the DON revealed the Administrator and the DON should be notified when additional allegations of abuse were discovered during an abuse investigation. The DON revealed the nursing supervisors should be reviewing</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>witness statements and additional allegations should be reported and additional investigations added. The DON revealed she had not reviewed the staff witness statements. The DON revealed she had not been notified of staff force feeding a resident. The DON verified the facility had not completed Self-Reported Incidents (SRI) for the additional allegations brought forward during the investigation of verbal abuse on 01/27/26. The DON revealed CNA #374 had talked to her on 01/30/26 and had never mentioned any abuse concerns during the two times she spoke with him. The DON also revealed staff should have followed up with necessary notifications and assessments for the residents with allegations of abuse. Interview on 02/04/26 at 2:39 P.M., RN #602 revealed he was aware of the allegation of CNA #400 force feeding residents. RN #602 revealed he had not reported the allegation as CNA #400 was already off from work on administrative leave. RN #602 revealed he should have reported the allegation as force feeding would be considered abusive. RN #602 revealed he could not recall if DS #367 had reported allegations of resident mistreatment by CNA #400 in the past. Interview on 02/04/26 at 4:15 P.M., Dietary Supervisor (DS) #610 revealed DS #367 had concerns regarding how a nursing assistant was treating the residents. DS #610 revealed he dialed RN #602's number for DS #367 to speak with RN #602. DS #610 revealed he heard DS #367 reporting to RN #602 about a nursing assistant being mean to the residents. Interview on 02/05/26 at 8:16 A.M., Licensed Social Worker (LSW) #312 revealed she was not made aware of the allegation of verbal abuse toward Resident #97 until yesterday. LSW #312 revealed the facility was supposed to notify her of allegations of abuse. LSW #312 also revealed psychiatric services should be notified quickly to follow up with residents with allegations of abuse. Interview on 02/05/26 at 9:30 A.M., the ADON #370 revealed whoever was covering the unit at the time of the allegation should have notified social services, the physician, and the psychiatric services provider. ADON #370 verified the psychiatric services provider was not notified until several days later. Further interview with ADON #370 revealed she was aware of an allegation of former Resident #243 being force fed but she had talked to the resident's wife who said the resident had not been force fed. ADON #370 verified the allegation was not reported or further investigated. Review of the facility policy Reporting Allegation of Abuse/Neglect/Exploitation, dated 03/25/25 revealed the facility would investigate all allegation of alleged violations by identifying and interviewing all involved person, including the alleged victim, alleged perpetrator, witnessed, and others who might have knowledge of the allegations. The facility would provide complete and thorough documentation of the investigation. Further review of the policy revealed the facility would respond to the residents' needs and protect from further incidents, remove the accused, notify the Administrator, notify the facility police department, notify the physician and resident's family/legal representative. Also, the facility would monitor and document the resident's condition, including response to medical treatment or nursing interventions and document actions taken in the medical record. Review of the facility policy Abuse, Neglect, Exploitation, dated 03/25/25 revealed all alleged violations of any form of abuse would be reported immediately, but no later than two hours after the allegation was made if the events cause the involve abuse or serious bodily injury. The Administrator would report allegations or suspected abuse to the state survey agency and other officials in accordance with state law. Only the Administrator in consultation with the Superintendent and Chief Compliance Office can determine if abuse occurred. The facility would immediately protect the alleged victim and integrity of the investigation. The facility would examine the alleged victim for any sign of injury, including a physician examination or psychosocial assessment if needed, provide emotional support and counseling to the resident during and after the investigation as needed. This deficiency represents non-compliance investigated under Complaint Number 2731992.</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, review of staff statements, staff interview, and policy review, the facility failed to ensure food items were provided per physician orders. This affected one (#93) of three residents reviewed for dietary services and had the potential to affect 14 residents identified by the facility with physician orders for mechanically altered diet textures. The facility census was 242. Findings include: Review of the medical record for Resident #93 revealed an admission date of 09/05/18. Diagnoses included hemiplegia and hemiparesis, dementia, type two diabetes mellitus, and dysphagia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment. The resident was dependent on staff for feeding assistance. Review of the care plan last revised 02/03/26 revealed the resident was at risk for aspiration due to a history of dysphagia. Interventions included to monitor for choking and for signs/symptoms of aspiration and notify physician as needed. Review of the nutritional care plan last revised 12/03/24 revealed the resident was at nutritional risk due to dementia, diabetes mellitus, chronic kidney disease, and dysphagia. Interventions included a high protein diet, pureed texture, nectar consistency via noney cup with three to four pumps thickener. Additional interventions included to monitor for chewing/swallowing problems or choking. Also for direct one to one supervision with small bite sizes, slowed rate of consumption, and alternation of foods/drinks every two to three bites. Review of the physician orders dated 12/22/25 revealed Resident #93 was ordered a high protein, pureed texture diet with nectar consistency. Further review of physician orders dated 08/14/25 revealed the resident required direct one to one supervision with implementation of small bites, slowed rate of consumption, and alternation of foods/drinks every two to three bites. Review of an undated witness statement by Dietary Staff (DS) #367 revealed on 01/27/26 Certified Nursing Assistant (CNA) #400 was always telling her to do things other than what was on the meal tickets for the residents. Review of a witness statement dated 01/28/26 by Speech Therapist (ST) #324 revealed on 01/27/26 he had been informed by a nursing assistant that CNA #400 had provided Resident #93 with a banana during snack time despite the resident being on a pureed diet and without his direct presence on the unit. ST #324 revealed the resident had an order for direct one to one assistance/supervision due to an extensive history of suspected aspiration/penetration episodes during intake. Review of a witness statement dated 01/29/26 by CNA #400 revealed CNA #400 was asked if she had given residents food or requested items not listed on the meal ticket. CNA #400 responded yes. CNA #400 was asked if she had given resident food items that had not followed their diet order such as giving a resident a banana who had a pureed diet order. CNA #400 responded yes and noted she had approval from ST #324 as long as the resident was awake and alert. Further review of the medical record, assessments, and nurse's notes dated 01/29/26 revealed no documentation Resident #93 had a respiratory assessment after receiving food with the incorrect texture per dietary orders. Interview on 02/03/26 at 1:36 P.M., ST #324 revealed CNA #350 had reported CNA #400 gave Resident #93 a whole banana despite prior education on following dietary orders. ST #324 revealed the resident was on a pureed diet and he had never okayed the resident getting a banana without his direct supervision. ST #324 revealed the resident was at risk for aspiration. ST #324 revealed he had not assessed the resident after he was notified the resident was given the banana. ST #324 revealed he reported the incident to a nursing supervisor. Interview on 02/03/26 at 3:12 P.M., CNA #350 revealed CNA #400 would serve residents the incorrect diet textures. CNA #350 revealed Resident #93 required a pureed diet but CNA #400 gave the resident a whole banana for breakfast on 01/27/26. Interview on 02/04/26 at 9:54 A.M., Registered Nurse (RN) #342 revealed ST #324</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>reported CNA #400 gave a resident the wrong food and had also done this in the past with the behavior continuing. Interview on 02/024/26 at 1:46 P.M., the Director of Nursing (DON) verified there was no documentation Resident #93 had a respiratory assessment completed on 01/27/26 after being given the wrong textured food item. Review of the facility policy Dysphagia, dated 08/19/24, revealed the food service manager would follow any written orders for diet and fluid consistency and educate staff and supervise preparation of altered consistency diets. The nursing staff would follow any written physician orders. This deficiency represents non-compliance investigated under Complaint Number 2731992.</p>		