STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366333	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scenic Pointe Nursing and Rehab Ctr	8067 Township Road 334 Millersburg, OH 44654

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review the facility failed to ensure Resident #4 received an updated Preadmission Screening and Resident Review (PASRR) after mental health diagnoses was identified. This affected one (Resident #4) of two residents reviewed for PASRR. The facility census was 131.Findings include: Review of the medical record for Resident #4 revealed an admission date of 02/15/19. Diagnoses included unspecified psychosis not due to a substance or known physiological condition, dementia with behavioral disturbance, and cognitive communication disorder. On 04/18/25 recurrent major depression was added to the resident diagnoses list.Review of Resident #4's physician orders dated 05/2026 revealed the resident was receiving Depakote Extended Release 500 milligram (mg) with instructions to give three tablets in the evening for unspecified psychosis not due to a substance or known physiological condition and Sertraline 200 mg with instructions to take one capsule by mouth one time a day related to major depressive disorder.Review of Resident #4's PASRR Identification Screen revealed the assessment was completed on 11/14/2008 prior to the resident's admission to the facility. At the time of completion, the PASRR had not identified that the resident had any mental health disorders.Interview on 05/07/2026 at 11:39 A.M. with the Director of Social Services #316 verified the facility had not obtained an updated PASSAR which included Resident #4's mental health diagnoses. The Director of Social Services #316 verified the facility did not have a policy related to PASSAR.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and policy review the facility failed to ensure pressure ulcer treatments were completed as ordered by the wound practitioner for Resident #109. This affected one resident (#109) of one resident reviewed for pressure ulcers. The facility census was 131.Findings include: Review of Resident #109's medical record revealed an admission date of 09/26/22 with diagnoses including type two diabetes mellitus, moderate intellectual disabilities, vascular dementia, bipolar disorder, psoriasis, repeated falls, and venous insufficiency. Review of Resident #109's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had moderately impaired cognition. Review of Resident #109's plan of care dated 03/09/26 revealed the resident had a pressure ulcer on his sacrum. Interventions included assessing the area weekly and as needed, assessing for pain and treatment as ordered, bariatric air mattress with bolsters, body check weekly, and providing treatment as ordered.Review of Resident #109's wound care note dated 03/09/26 revealed the resident had an unstageable pressure ulcer to the sacrum and was being seen for the first time. The wound measured 5.5 centimeters (cm) by 2.5 cm by an undetermined depth. The care provider ordered to cleanse the pressure ulcer with normal saline, apply calcium alginate, and cover with silicone super absorbent dressing once a day.Review of Resident #109's physician order dated 03/09/26 to 03/23/26 revealed an order to cleanse the area with normal saline, pat dry, pack one calcium alginate pad inside and cover with one calcium alginate pad and super absorbent foam, once a day and as needed.Review of Resident #109's wound practitioner note dated 03/16/26 revealed the unstageable pressure ulcer was present but improving. The wound care order starting 03/16/26 was to cleanse with normal saline, use 0.25% Dakins moistened gauze, and cover with silicone super absorbent dressing twice a day and as needed. Calcium alginate could be used until Dakins arrived. Review of Resident #109's Treatment Administration Record (TAR) from 03/16/26 through 03/22/26 revealed his treatment was completed once a day.Review of Resident #109's wound practitioner note dated 03/23/26 revealed the unstageable pressure ulcer was present but improving. The wound care order starting 03/23/26 was to cleanse with normal saline, use 0.125% Dakins moistened gauze, and cover with silicone super absorbent dressing twice a day and as needed. Calcium alginate could be used until Dakins arrived. Review of the Treatment Administration Record (TAR) from 03/23/26 to 04/26/26 revealed Resident #109's wound treatment was completed once a day. Review of Resident #109's physician order dated 03/23/26 to 05/04/26 revealed an order to cleanse the sacrum, pat dry, pack with Dakins External Solution 0.125% moistened gauze and cover with silicone super absorbent dressing, once a day and as needed.Review of Resident #109's wound practitioner notes dated 03/30/26, 04/06/26, and 04/20/26 revealed the unstageable pressure ulcer was present but improving. The wound care order that had been initiated on 03/23/26 remained in place and treatment was ordered to occur twice a day. Review of Resident #109's wound practitioner note dated 04/27/26 revealed the pressure ulcer was a stage three. The wound had improved and was measuring 1.5 cm by 1.0 cm by 0.4 cm. The order remained in place and treatment was supposed to occur twice a day. Review of Resident #109 Treatment Administration Record (TAR) from 04/27/26 to 05/03/26 revealed the wound treatment was completed once a day. Review of Resident #109's progress note dated 05/04/26 revealed orders were clarified with the wound practitioner, and the current treatment was to be applied twice a day.Interview on 05/06/26 at 12:05 P.M. with the Director of Nursing (DON) revealed facility staff did wound rounds with the wound practitioner to receive updates and new orders. Additionally, they received the wound notes which contained the orders. Facility staff entered the practitioner's orders into the electronic medical record. The DON verified the facility had been doing wound treatment on Resident #109 once a day when the wound practitioner had ordered it twice a day. The DON was unsure why or how the discrepancy occurred. They notified the practitioner on 05/04/26 who verified she wanted the order twice a day as this was best practice for Dakins.Review (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the policy ?Wound assessment' dated 09/29/17, revealed wound should be assessed and monitored to determine if the treatment plan was working or should be reevaluated. Following assessments, new dressings were to be applied as ordered.