

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2025
NAME OF PROVIDER OR SUPPLIER National Church Residences Chillicothe		STREET ADDRESS, CITY, STATE, ZIP CODE 142 University Drive Chillicothe, OH 45601	
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure Pre-admission Screening and Resident Reviews (PASARR) were completed and updated to reflect a new qualifying diagnosis. This affected two (#5 and #38) of two residents reviewed for PASARR accuracy. The facility census was 36. Findings include: 1. Review of Resident #38's medical record revealed an admission date of 01/09/24. Diagnoses included acute and chronic respiratory failure with hypoxia, congestive heart failure, type II diabetes, atrial fibrillation, mild cognitive impairment of unknown etiology, dysphagia, generalized anxiety disorder, drug induced subacute dyskinesia, major depressive disorder, and fibromyalgia. Further review revealed a diagnoses with onset date of 09/26/23 of unspecified psychosis not due to a substance or known physiological condition, and fibromyalgia. Review of Resident #38's Minimum Data Set (MDS) assessment dated [DATE] revealed anxiety disorder, depression (other than bipolar), and psychotic disorder (other than schizophrenia) as diagnoses for Resident #38 under, Section I &ndash; Active Diagnoses. Review of Resident #38's Preadmission Screening and Resident Review (PASARR) Identification Screen dated 01/11/24 revealed, in section E, the diagnoses of mental disorders as mood behaviors and panic or other severe anxiety disorder only. The PASARR Identification Screen Results revealed no indications of serious mental illness nor a developmental disability. Interview on 12/31/25 at 10:32 A.M. with Social Services Leader (SSL) #199 confirmed the PASARR Identification Screen dated 01/11/24 was the most recent version of the document for Resident #38. SSL #199 confirmed that other psychotic disorder was not captured as a diagnosis under section E of the PASARR. SSL #199 confirmed that, based on Resident #38 medical diagnoses in the medical record, other psychotic disorder should be captured as a medical diagnosis under section E of the PASARR. 2. Record review for Resident #5 revealed the resident was admitted to the facility on [DATE]. Diagnoses included seizures, aortic valve stenosis, chronic kidney disease, osteoarthritis, Alzheimer's disease, dementia, secondary Parkinsonism, convulsions, psychotic disorder, and anxiety. Review of an updated diagnosis list revealed a new diagnosis of psychotic disorder with delusions and hallucinations added on 11/05/25. Review of the quarterly MDS assessment dated [DATE] revealed Resident #5 had severely impaired cognition. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

Printed: 07/18/2026
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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the most recent PASARR documentation provided by the facility for Resident #5 revealed it was completed prior to admission on [DATE], with no further documentation which reflected the addition of the new diagnosis. Interview with the Director of Nursing on 12/30/25 at 3:03 P.M. verified a new PASARR had not been completed following the addition of the new diagnosis for Resident #5.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to develop a plan of care for residents with diagnoses of Alzheimer's disease and dementia. This affected one (#5) of 17 residents reviewed for care plans. The facility census was 36. Findings include: Record review for Resident #5 revealed the resident was admitted to the facility on [DATE]. Diagnoses included seizures, aortic valve stenosis, chronic kidney disease, osteoarthritis, Alzheimer's disease, dementia, secondary Parkinsonism, convulsions, psychotic disorder, anxiety, and psychotic disorder with delusions and hallucinations. Further review of the resident's diagnoses revealed Alzheimer's disease and dementia were added as new diagnoses on 12/01/25. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 had severely impaired cognition. Review of Resident #5's current comprehensive care plan, last revised on 12/17/25, revealed there was no care plan put into place to address Resident #5's care needs related to Alzheimer's disease and dementia. Interview with the Director of Nursing (DON) on 12/30/25 at 3:01 P.M. verified the facility did not develop a care plan to address Resident #5's care needs related to Alzheimer's disease and dementia.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident and resident family interview, and staff interview, the facility failed to provide care and services for the prompt treatment of a urinary tract infection. This affected one (#14) of three residents reviewed for urinary tract infections. The facility census was 36. Findings include: Record review for Resident #14 revealed the resident was admitted to the facility on [DATE]. Diagnoses included left femur fracture, anemia, acute respiratory failure, chronic kidney disease, falls, congestive heart failure, obesity, depression, gastro-esophageal reflux disease, and polyneuropathy. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #14 had no cognitive impairment. The resident was also assessed to be occasionally incontinent of bladder and frequently incontinent of bowel. Review of a nursing note dated 12/22/25 at 12:17 P.M. revealed Resident #14 began complaining of dysuria (painful urination). A urinalysis with culture and sensitivity was documented as being ordered. Review of a nursing note dated 12/24/25 at 1:11 A.M. revealed a urine specimen had been collected and placed in the refrigerator for the laboratory to pick up. Review of a nursing note dated 12/26/25 at 8:55 A.M. revealed all laboratory results were received with all parties being notified including the resident, family, and medical professional. Review of a nursing note dated 12/27/25 at 12:15 P.M. revealed facility staff were notified by the resident's daughter that the laboratory results had been reviewed on the resident's electronic medical record, and no antibiotics had been initiated for treatment of a positive urinary tract infection. An order for an antibiotic was obtained at that time for Bactrim double strength (DS) 800-160 milligrams (mg), one (1) tablet by mouth twice daily for seven days. Review of the December 2025 medication administration record (MAR) for Resident #14 revealed the first dose of the antibiotic was provided on 12/27/25 at 8:00 P.M. Interview with Resident #14 and her daughter on 12/29/25 at 10:37 A.M. revealed she first started experiencing symptoms of a urinary tract infection on 12/22/25, and it was more than five days before treatment was started with an antibiotic. Both Resident #14 and her daughter stated treatment was delayed from the beginning of symptoms which was unacceptable. Interview with the Director of Nursing (DON) on 12/30/25 at 3:05 P.M. verified there was a delay in the treatment of a urinary tract infection for Resident #14. The DON verified treatment should have been initiated sooner, considering the resident began complaining of symptoms on 12/22/25.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, and staff interview the facility failed to ensure medications were administered as ordered to maintain a medication error rate less than five percent (%). A total of three medication errors were observed out of 38 opportunities for a medication error rate of 7.89%. This affected three (#8, #20, and #34) of five residents observed during medication administration. The census was 36. Findings Include:1. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE]. Diagnoses included type II diabetes mellitus, cirrhosis of the liver, acquired absence of the right leg above the knee, and chronic kidney disease, stage three. Review of Resident #8's current physician orders revealed an order for insulin aspart three (3) units subcutaneously (SQ) via injector pen before meals with instructions to hold for a blood glucose level less than 200 milligrams per deciliter (mg/dL).Observation of medication administration on 12/31/25 at 8:45 A.M. revealed Licensed Practical Nurse (LPN) #201 obtained Resident #8's blood glucose level with a reading of 245 mg/dL. LPN #201 then prepared medications to administer to Resident #8 including the resident's insulin aspart 3 units SQ. Further observation revealed she did not prime the injector pen prior to dialing in the ordered dose of insulin and then injected Resident #8 with the insulin.2. Review of the medical record revealed Resident #34 was admitted to the facility on [DATE]. Diagnoses included type II diabetes mellitus, chronic diastolic heart failure, and atrial fibrillation.Review of Resident #34's current physician orders revealed an order for insulin lispro sliding scale insulin administered SQ via injection pen. The sliding scale orders included for blood glucose levels between 251 and 300 mg/dL, give 12 units of insulin before meals and at bedtime for diabetes.Observation of medication administration on 12/31/25 at 8:28 A.M. revealed LPN #201 obtained Resident #34's blood glucose level with a reading of 285 mg/dL. LPN #201 determined Resident #24 would require 12 units of insulin based on the sliding scale order and proceeded to dial up the required dose without first priming the injector pen. Further observation revealed LPN #201 administered the insulin to Resident #34.3. Review of the medical record revealed Resident #20 was admitted to the facility on [DATE]. Diagnoses included fracture of an unspecified part of the left femur, fracture of the right pubis, Parkinson's disease, and dementia.Review of Resident #20's current physician orders revealed an order for ascorbic acid oral tablet 100 milligrams (mg) one tablet by mouth one time a day.Observation of medication administration on 12/31/25 at 8:01 A.M. revealed LPN #201 prepared medications to administered to Resident #20 and it was noted the resident's ascorbic acid was not available. LPN #201 proceeded to administer all other scheduled medications to the resident and the ascorbic acid was omitted.Interview on 12/31/25 at 9:20 A.M. with LPN #201 confirmed the insulin pens for Resident #8 and Resident #34 were not primed prior to administration and should have been which resulted in an incorrect dose being administered. Continued interview with LPN #201 revealed she could not locate the ordered ascorbic acid for Resident #20 and resulted in an omitted medication.Interview on 12/31/25 at 9:25 A.M. with the Director of Nursing (DON) stated all insulin administration injector pens should be primed after putting the needle on and before administering the dose. The DON stated the injector pens should be primed with two units of insulin and then the dose should be dialed up and given after priming it.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, and staff interview, the facility failed to ensure medications were administered as ordered resulting in significant medication errors. This affected two (#8 and #34) of five residents observed during medication administration. The census was 36. Findings Include:1. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE]. Diagnoses included type II diabetes mellitus, cirrhosis of the liver, acquired absence of the right leg above the knee, and chronic kidney disease, stage three. Review of Resident #8's current physician orders revealed an order for insulin aspart three (3) units subcutaneously (SQ) via injector pen before meals with instructions to hold for a blood glucose level less than 200 milligrams per deciliter (mg/dL). Observation of medication administration on 12/31/25 at 8:45 A.M. revealed Licensed Practical Nurse (LPN) #201 obtained Resident #8's blood glucose level with a reading of 245 mg/dL. LPN #201 then prepared medications to administer to Resident #8 including the resident's insulin aspart 3 units SQ. Further observation revealed she did not prime the injector pen prior to dialing in the ordered dose of insulin and then injected Resident #8 with the insulin.2. Review of the medical record revealed Resident #34 was admitted to the facility on [DATE]. Diagnoses included type II diabetes mellitus, chronic diastolic heart failure, and atrial fibrillation. Review of Resident #34's current physician orders revealed an order for insulin lispro sliding scale insulin administered SQ via injection pen. The sliding scale orders included for blood glucose levels between 251 and 300 mg/dL, give 12 units of insulin before meals and at bedtime for diabetes. Observation of medication administration on 12/31/25 at 8:28 A.M. revealed LPN #201 obtained Resident #34's blood glucose level with a reading of 285 mg/dL. LPN #201 determined Resident #24 would require 12 units of insulin based on the sliding scale order and proceeded to dial up the required dose without first priming the injector pen. Further observation revealed LPN #201 administered the insulin to Resident #34. Interview on 12/31/25 at 9:20 A.M. with LPN #201 confirmed the insulin pens for Resident #8 and Resident #34 were not primed prior to administration and should have been which resulted in an incorrect dose being administered. Continued interview with LPN #201 revealed she could not locate the ordered ascorbic acid for Resident #20 and resulted in an omitted medication. Interview on 12/31/25 at 9:25 A.M. with the Director of Nursing (DON) stated all insulin administration injector pens should be primed after putting the needle on and before administering the dose. The DON stated the injector pens should be primed with two units of insulin and then the dose should be dialed up and given after priming it.		