| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366360 | A. Building<br>B. Wing | 04/28/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Vineyards at Concord, The | 119 West High Street<br>Frankfort, OH 45628 |

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) |
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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, medical record review and interview, the facility failed to provide residents who were dependent on staff for nail care. This affected two residents (#15 and #19) of five residents reviewed for activities of daily living (ADL). The facility census was 27. Findings Include:1. Review of the medical record for Resident #15 revealed an initial admission date of 04/20/25 with the latest readmission of 05/25/25 with the diagnoses including but not limited to neuropathy, peripheral vascular disease, hypertensive heart disease, vascular dementia, major depressive disorder, cerebral infarction, dementia, hypertension, gout, insomnia and anxiety disorder. Review of the plan of care not dated revealed the resident had an activity of daily living (ADL) self-care performance deficit related to cerebrovascular accident, restlessness and dementia. Interventions check nail length, trim and clean on bath day and as necessary. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. The resident was dependent on staff for personal hygiene. On 4/13/26 at 10:46 A.M., observation of the resident revealed his nails were long, jagged with a brown substance under the nail bed. On 04/14/26 at 12:41 P.M., observation of the resident's nails remained long, jagged with a brown substance under the nail bed. On 04/14/26 at 12:43 P.M., an interview with the Director of Nursing (DON) verified the resident's nails were long, jagged with a brown substance under the nail bed and in need of nail care. 2. Review of the medical record for Resident #19 revealed an initial admission date of 04/19/22 with the latest readmission of 06/30/24 with the diagnoses including but not limited to hypertensive heart disease, pain, hypertension, resistance to multiple antibiotics, atrial fibrillation, dementia with anxiety, insomnia, major depressive disorder, Alzheimer's disease, anxiety disorder, psychosis, gastro-esophageal reflux disease, gastritis, fatty liver, major depressive disorder and constipation. Review of the plan of care dated 04/20/22 revealed the resident had altered activities of daily living (ADL) function. Interventions included notify resident of ADL needed to be completed before starting, assess level of orientation and reorient as needed and able, provide set-up, supervision, cues and assist thru completion as warranted and as needed, allow and encourage resident to participate in own ADL at own optimum level of function as resident is able, praise efforts and compliment appearance as warranted, notify physician of any significant changes, when resident resists/refuses ADL completion redirect or provide rest break and reapproach, assist with clothing choices as needed and oral care daily and as needed. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed had a server cognitive deficit. Review of the mood and behavior revealed the resident had no indicators for depression and displayed no behaviors including rejection of care. The resident was dependent on staff for toileting and personal hygiene. On 04/13/26 at 10:46 A.M., observation of the resident revealed her nails were long, jagged and dirty with a brown substance under the nails. On 04/14/26 at 12:41 P.M., observation of the resident revealed her nails were long, jagged and dirty with a brown substance under the nails. On 04/14/26 at 12:43 P.M., an interview with the Director of Nursing (DON) verified the resident's nails were long, jagged with a brown substance under the nail bed and in need of nail care. On 04/15/26 at 4:16 P.M., an interview with the Licensed Nursing Home Administrator (LNHA) revealed the facility had no policy related to<br>(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 |
|---|---|---|

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | care of the resident's nails. This deficiency represents noncompliance investigated under Complaint Number 2984105. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review and interview, the facility failed to provide routine incontinence care. This affected two residents (#15 and #19) of three residents reviewed for bowel and bladder. The facility census was 27. Findings Include:1.Review of the medical record for Resident #15 revealed an initial admission date of 04/20/25 with the latest readmission of 05/25/25 with the diagnoses including but not limited to neuropathy, peripheral vascular disease, hypertensive heart disease, vascular dementia, major depressive disorder, cerebral infarction, dementia, hypertension, gout, insomnia and anxiety disorder. Review of the plan of care not dated revealed the resident had bladder incontinence related to dementia. Interventions included notify nursing if incontinent during activities, encourage fluids during the day to promote promoted voiding responses, establish voiding patterns, monitor and document intake and output as per facility policy, monitor fluid intake to determine if natural diuretics are contributing to increased urination and incontinence, monitor for sign/symptoms for urinary tract infection (UTI) and monitor/document/report to physician as needed possible medical causes of incontinence. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. The resident was dependent on staff for toileting needs and personal hygiene. The resident was always incontinent of bladder and frequently incontinent of bowel. On 4/13/26 at 10:46 A.M., observation of the resident revealed he was sitting at the dining room table finishing his breakfast. On 04/13/26 at 12:57 P.M., observation of the resident revealed he remains at the dining room table and had been sitting at the dining room table since entrance for the survey at 8:00 A.M. On 04/13/26 at 1:40 P.M., observation of the resident revealed he remains at dining room table. On 04/13/26 at 3:15 P.M., observation of the resident revealed he remained sitting in the dining room with his pants notably wet near his groins. On 04/13/26 at 3:20 P.M., an interview with Certified Nursing Assistant (CNA) #117 verified the resident's pants were saturated with urine and routine incontinence care had not been provided. 2. Review of the medical record for Resident #19 revealed an initial admission date of 04/19/22 with the latest readmission of 06/30/24 with the diagnoses including but not limited to hypertensive heart disease, pain, hypertension, resistance to multiple antibiotics, atrial fibrillation, dementia with anxiety, insomnia, major depressive disorder, Alzheimer's disease, anxiety disorder, psychosis, gastro-esophageal reflux disease, gastritis, fatty liver, major depressive disorder and constipation. Review of the plan of care dated 05/01/23 revealed the resident had actual bladder incontinence related to dementia, Alzheimer's disease, need for assistance with personal care. Interventions included resident to toilet every two hours, provide set-up, supervision and assist as needed with toileting/cleansing, therapy services as physician ordered, may utilize double briefs depends during the day to protect dignity, provide peri-care as necessary to maintain proper hygiene for clean, dry and odor free and observe for signs/symptoms of urinary tract infection (UTI). Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed had a server cognitive deficit. Review of the mood and behavior revealed the resident had no indicators for depression and displayed no behaviors including rejection of care. The resident was dependent on staff for toileting and personal hygiene. The resident was always incontinent of both bowel and bladder. Review of the progress notes for 04/13/26 revealed no documented evidence the resident refused toileting on day shift. On 4/13/26 at 10:46 A.M., observation of the resident revealed he was sitting at the dining room table finishing his breakfast. On 04/13/26 at 12:57 P.M., observation of the resident revealed he remains at the dining room table and had been sitting at the dining room table since entrance for the survey at 8:00 A.M. On 04/13/26 at 1:40 P.M., observation of the resident revealed he remains at dining room table. On 04/13/26 at 3:20 P.M., observation of CNA #117 and #127 provide incontinence care for the resident revealed they wheeled her to her room from the dining<br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | room where she had been sitting since 8:00 A.M. upon entry to the facility. The staff sanitized their hands and donned gloves. The resident was placed on the toilet in the bathroom via two assists and the resident using the grab bar. The resident's pants were pulled down and revealed the resident had a blue brief on and a large liner that was completely saturated with a strong ammonia smelling urine. CNA #117 revealed the resident was supposed to be toileted every hour and a half. CNA #127 stated, the resident had not been toileted for quite some time. The resident was provided incontinence care and an incontinence pull-up brief was placed on the resident. This deficiency represents noncompliance investigated under Complaint Number 2984105. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, hospital record review and policy review, the facility failed to provide a comprehensive, resident centered plan of care to prevent, timely identify, and treat weight loss for residents. Additionally, the facility failed to ensure weights were obtained, documented, and monitored for weight loss, failed to ensure meal intake percentages were documented at every meal, and failed to ensure supplements were provided per order and failed to follow the recipe for supplements to ensure residents received the proper nutritional support. This affected two (Residents #4 and #8 ) of three residents reviewed for nutrition/weight loss. The facility census was 27.Findings include:1.Review of Resident #8's medical record revealed an admission date of 12/23/25 with diagnoses including Alzheimer's disease, general anxiety, and abnormal weight loss.<br><br>Review of a physician's order dated 12/23/25 revealed Resident #8 received a regular diet with thin liquids.<br><br>Review of Resident #8's nutrition assessment dated [DATE] revealed a diagnosis of abnormal weight loss. The Administrator (LNHA), who is also a registered dietician (RD) and was serving as RD at that time, recommended the addition of four ounces of a nutritional supplement between meals or with meals as tolerated. There was no mention of what type of supplement in the nutritional assessment. Further review revealed Resident #8 had a decline in meal intakes and refuses to eat before admission and low appetite continues due to fast paced dementia/Alzheimers and refusals and is hospice appropriate. Resident #8 is easily agitated.<br><br>Review of the medical record revealed there was no order for a nutritional supplement as recommended on 12/26/25.<br><br>Review of the progress note dated 12/30/25 by Family Nurse Practitioner (FNP) #132 documented Resident #8 was in no acute distress. FNP #132 acknowledged Resident #8 had an abnormal weight loss of 14.8 pounds, from 171.6 lbs. on 11/07/25 to 156.8 lbs. on 12/22/25 while admitted to hospital prior to facility admission. The plan was to continue to monitor weight. No other specific interventions were discussed in the note.<br><br>Review of the progress note dated 01/06/26 by FNP #132 documented Resident #8 was in no acute distress. The follow-up visit was for abnormal weight loss prior to admission and mental health issues. The etiology of the weight loss was likely due to her mental disorders. The plan was to continue monitoring weight and nutritional intake as indicated and further workup to be considered if weight loss continued.<br><br>Review of the History and Physical dated 01/08/26 written by Medical Director #131 documented Resident #8 had experienced a significant weight loss prior to admission. The assessment and plan did not address abnormal weight loss.<br><br>Review of the progress notes dated 01/13/26, 01/20/26, and 02/19/26 by FNP #132 did not mention or address weight loss.<br><br>Review of the weights revealed Resident #8 weighed 132 lbs. in February 2026. This was a 25 lb. weight loss from admission.<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the physician visit note dated 02/19/26 written by Medical Director #131 did not address weight loss.<br><br>Review of progress note dated 02/24/26 by FNP #132 did not mention or address weight loss.<br><br>Review of a nutrition note dated 02/27/26 by RD #120 documented Resident #8 triggered for significant weight loss of 13.2 percent in 30 days. RD #120 to add house shakes three times a day 120 milliliters (ml) for additional 240 kilocalories (kCals) and 10 grams (g) of protein to help stabilize weight.<br><br>Review of progress note dated 03/10/26 by FNP #132 did not mention or address weight loss.<br><br>Review of the physician visit note dated 03/19/26 at 12:27 P.M. and written by Medical Director (MD) #131 did not address significant weight loss.<br><br>Review of progress notes dated 03/24/26 and 04/07/26 by FNP #132 did not mention or address continued weight loss.<br><br>Review of weights for Resident #8 weighed 125.5 lbs. in April 2026, a loss of 7.5 lbs. since March 2026.<br><br>Review of Resident #8's physician orders for February, March and April 2026 revealed no order for the supplements as recommended on 02/27/26 by RD #120.<br><br>Review of Resident #8's meal ticket revealed a regular diet with no order for nutritional supplements written on the meal ticket.<br><br>Review of Resident #8's care plan revealed a nutrition care plan revised on 03/28/26 for a nutritional problem related to weight loss prior to admission. The goal was for Resident #8 to maintain adequate nutritional status. Interventions for Resident #8 included encourage resident to remain compliant with diet/orders. Blood sugar checks as necessary, monitor for signs or symptoms of hypo/hyperglycemia, follow endocrine plan of care if warranted, encourage compliance with medications and treatment orders, follow up with specialty physician, monitor weights as necessary, monitor for choking hazards/episodes, notify Medical Director as warranted if any significant changes. Provide and encourage resident to drink supplements when awake and when resident consumes less than 75 percent, utilize nosey cup when able, and feed her meals or hardy snacks when up and out of bed during night and non-mealtimes.<br><br>Review of Resident #8's Minimum Data Set (MDS) assessment, dated 04/07/26, revealed Resident #8 was severely cognitively impaired. She required supervision with eating. No weight loss was reflected in the assessment.<br><br>Review of the resident's meal percentages for breakfast, lunch and dinner from 02/27/26 through 04/12/25 revealed the resident's meal intake varied from day to day and meal to meal. There were no percentages of meals eaten written down for 02/27/26, 02/28/26, 03/01/26 through 03/10/26 and again from 03/13/26 through 03/31/26. There was no documentation of meals on 04/11/26 and 04/12/26.<br><br>Further review of the meal percentage sheets revealed some inconsistencies if Resident #8 received<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | or accepted any type of dietary supplement.<br><br>Observation on 04/13/26 during lunch meal revealed Resident #8 got up from tabel a couple of times and teh kitchen gave her a sandwhich and grapes and she ate them in the lobby area. No observations of Resident #8 with supplements.<br><br>During an interview on 04/15/26 at 4:25 P.M., RD #120 stated resident meal intake documentation was not consistently filled out by staff.<br><br>During an interview on 04/16/26 at 10:08 A.M MD #131 stated he deferred to the RD's decision regarding supplements offered. MD #131 was not aware Resident #8 had severe weight loss due to current weights not updated in the resident's electronic record. In the system it looked as if weight had stabilized. MD #131 stated weight loss notifications would be made to FNPP #132.<br><br>2. Review of the medical record for Resident #4 revealed an initial admission date of 01/02/26 with a readmission date of 02/17/26 following a fall at the facility resulting in a displaced spiral fracture of shaft of right femur. Diagnoses included displaced spiral fracture of shaft of right femur, moderate protein calorie malnutrition, neuromuscular dysfunction of bladder, encounter for palliative care, anemia, osteoporosis, diabetes mellitus, insomnia, hypertensive heart disease, hyperlipidemia, delusional disorder, hypertension, history of falling, history of nontraumatic fracture<br><br>Review of the hospital summary dated 02/17/26 the resident's family requested the resident to return to the facility with hospice services.<br><br>Review of the resident's significant change MDS assessment dated [DATE] revealed the resident had a severe cognitive deficit. The resident required supervision or touching assistance with eating. Resident #4's weight was 103 lbs. with a significant weight loss and not on a prescribed weight loss regimen. The resident was on a therapeutic diet.<br><br>Review of the resident's weights revealed on 01/02/26, Resident #4 weighed 109 lbs on admission. On 01/15/26, the resident weighed 103.5 lbs, which was a five percent loss in 30 days. On 02/27/26, the resident weighed 102.5 lbs .<br><br>Review of the nutrition progress note dated 02/27/26 revealed the resident's current body weight was 102.5 pounds with a body mass index (BMI) of 20, which was underweight for age greater than 65 years. Weight review indicates significant weight loss of 5.9 percent in thirty days. The resident was receiving a regular diet and meal intakes were 10 to 50 percent of meals. The resident was receiving hospice care services, and the weight loss was anticipated due to six month or less prognosis. The goal was for dignity and comfort at this time. The RD was to continue to monitor and follow up as needed.<br><br>Review of the progress note dated 02/27/26 revealed the RD recommended adding house shakes twice daily for an additional 240 calories and 10 grams of protein per serving. The dietary manager was made aware, and the resident was added to the supplement list.<br><br>On 03/02/26, the resident weighed 89.5 lbs., which was a 12.68 percent loss in five days. Residen#4's weight for April 2026 was 90 lbs.<br><br>Review of the medical record revealed no evidence the resident was reweighed to determine if the<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | weight loss of 12.68 percent in five days was accurate.<br><br>Review of the medical record revealed no evidence that an initial nutritional assessment from the 01/02/26 admission was completed to determine the resident's nutritional needs.<br><br>Review of the medical record revealed no evidence the RD recommendations for house supplement twice daily was implemented.<br><br>Review of the resident's plan of care revealed no care plan addressing the resident's nutritional status, including weight loss.<br><br>On 04/15/26 at 3:30 P.M., an interview with [NAME] #118 revealed the house supplement is made with milk and a Whey protein powder blend supplement with creatine and ammino acids. The cook revealed the house supplement was not for weight loss, but for extra protein. [NAME] #118 revealed she had no recipe she followed to make the supplement from the whey protein powder and at times will add ice cream, fruit or peanut butter. The cook revealed she made a gallon of the supplement at a time. [NAME] #118 verified the facility does stock Ready Pass.<br><br>On 04/15/26 at 4:41 P.M., an interview with the RD, revealed she was aware the facility was using the whey protein powder and recommended to stop the use due to the inconsistency of how the supplement was prepared. The RD revealed she recommended all residents who were to receive the house supplement was to receive Ready Pass supplement for preventative and/or actual weight loss.<br><br>On 04/16/26 at 8:40 A.M., an interview with [NAME] #129 revealed the facility only had two residents (#8 and #16) who received the Ready Pass. The [NAME] revealed all other residents receive the house supplement made from the Whey protein powder blend supplement with creatine and ammino acids.<br><br>On 04/16/26 at 10:08 A.M., an interview with the Medical Director (MD) revealed he was not aware of the facility using the whey protein powder and recommended the use of supplements the RD recommended.<br><br>During an interview on 04/16/26 at 12:40 P.M., the Administrator verified the resident had no plan of care addressing the resident's nutritional status and weight loss, no initial comprehensive nutritional assessment at the RD recommendations were not implemented.<br><br>This deficiency represents non-compliance investigated under Complaint Number 2984105. |

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| F 0800<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.<br><br>Based on observation and staff interviews the facility failed to follow diet orders when dietary staff served mechanical textured meat to residents on a regular diet during lunch meal. This had the potential to affect 18 ( #1, #2, #4, #6, #7, # 8, #11, #13, #14, #18, #21, #22, #23, #24, #25, #26, #27, and #29) who receive a regular diet. The facility census was 27. Observation on 04/15/26 at 12:15 P.M. with [NAME] #118 revealed the lunch meal was pork and sauerkraut, mashed potatoes and bread pudding. The pork and sauerkraut were made into mechanical texture and served to residents who are on a regular diet. Associate #118 confirmed pork was mechanical texture and she does this so residents receive the same looking meat and to reduce choking hazard. Pureed pork and sauerkraut was made with milk. Associate #118 confirmed she used milk to puree pork and sauerkraut because it adds calories and nutrients. Review of the medical records revealed 18 ( #1, #2, #4, #6, #7, # 8, #11, #13, #14, #18, #21, #22, #23, #24, #25, #26, #27, and #29) residents received a regular diet. Interview on 04/15/26 at 1:58 P.M. with Administrator confirmed mechanical textured meat served to all regular diet residents is not appropriate and confirmed puree recipe exists for lunch meal but was not followed. This deficiency represents noncompliance investigated under Complaint Number 2984105. |

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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 observation, medical record review, interview and facility policy review revealed the facility failed to maintain infection control practices to prevent the potential spread of infection. This affected two residents (#5 and #20) of 15 residents reviewed for infection control. The facility census was 27.Findings Include:<br><br>1.Review of the medical record revealed Resident #5, specified, was admitted to the facility on [DATE]. Diagnoses included metabolic encephalopathy, severe dementia with anxiety, Alzheimer's disease, essential hypertension, and dysphagia.<br><br>Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition with hallucinations and delusions, rejected care, and did not wander.<br><br>Resident #5 is dependent for all care and has a gastric feeding tube placed.<br><br>Observation of gastric tube feed for Resident #5 on 04/14/2026 at 11:59 A.M. revealed that no personal protective equipment (PPE) was available outside of or inside the room and no gown was worn during tube feed procedure.<br><br>Interview with staff #132 on 04/14/2026 at 12:05 P.M. confirmed that proper PPE was not worn during tube feed, no gown and gloves are set up outside or inside the room and Resident #5 does not have enhanced barrier precaution orders placed<br><br>The enhanced barrier precautions sign on the door of Resident #5 states providers and staff must also: wear gloves and a gown for the following high-contact resident care activities Device care or use: .feeding tube.<br><br>Review of the medical chart for Resident #5 reveals no orders for enhanced barrier precautions exists.<br><br>2. Review of the medical record for Resident #20 revealed an initial admission date 03/27/26 with the diagnoses of including but not limited to pyothorax, anemia, elevated white blood cell count, presence of heart valve replacement, presence of prosthetic heart valve, osteoporosis, nicotine dependence, convulsions, hyperlipidemia, depression, pleural effusion, hypothyroidism, mood disorder, atrial fibrillation and generalized anxiety disorder.<br><br>Review of the plan of care dated 03/28/26 revealed the resident had a pneumonia like condition related to empyema, as evidenced by both lungs infiltrated with pus upon presentation to the hospital and intravenous antibiotic therapy. Interventions included monitor vital signs every shift, as needed and with any noted changes, monitor for fever every shift, observe for signs/symptoms persisting or onset of fever, increased cough, moist/loose cough, rales/rhonchi/wheezing, change in vital signs, increased pulse, increased respirations or changes in respiration, decreased oxygen saturation, sallow breathing, shortness of breath or change in level of consciousness, encourage fluids every two hours, keep head of bed elevated to assist with breathing, encourage deep breathing and coughing to assist with keeping lungs as clear as possible, courage to sit up out of bed as tolerated, encourage<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366360 | A. Building<br>B. Wing | 04/28/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Vineyards at Concord, The | 119 West High Street<br>Frankfort, OH 45628 |

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

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | resident, monitor lung sounds every shift and as needed, document progress in nurses notes with respiratory assessments, administer medications and treatments as ordered and follow up with repeat chest x-ray in 20 days or after antibiotic treatment unless doctor contraindicates or decides not to order.<br><br>Review of the resident's five-day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident's primary diagnosis was pyothorax and received antibiotic medications. The assessment indicated the resident was receiving intravenous medications.<br><br>Review of the resident's monthly physician orders for April 2026 identified orders dated 03/27/26 maintain midline intravenous (IV) patency, flush IV line with normal saline (NS) per policy for antibiotic infusion, 03/30/26 assess midline site every shift, maintain dressing to IV site, change dressing every seven days and as needed, 04/07/26 Ceftriaxone Sodium IV solution 2 grams IV daily for pyothorax until 04/19/26. Further review of the resident's physician orders both active and discontinued revealed no physician order for enhanced barrier precautions related to the midline IV therapy.<br><br>On 04/13/26 at 10:06 A.M., observation of the Director of Nursing (DON) administered the physician ordered medication Ceftriaxone Sodium IV solution 2 grams IV revealed she washed her hands, administered the resident her by mouth medications and set-up IV medication to administer. The DON then washed her hands, donned gloves and flushed the resident's peripherally inserted central catheter (PICC) line with five milliliters (ml) of normal saline (NS). She then connected the medication. The DON had donned no gown or mask for enhanced barrier precautions (EBP).<br><br>On 04/13/26 at 10:42 A.M., an interview with the DON verified she had not donned personal protection equipment for EBP while administering the IV medications. She verified the resident had not been on EBP, although should have been.<br><br>Review of facility policy titled Enhanced Barrier Precautions dated 01/25, states Appropriate PPE of gowns and gloves shall be worn when coming in close contact with residents whom have open routes to their interior body and or colonized MDRO infections. This includes but is not limited to: Feeding tubes, IV and PPE stations shall be set up with gowns and gloves outside or right inside the doorway of rooms.<br><br>This deficiency represents noncompliance investigated under Complaint Number 2984105. |