STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366412	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Als Mount Vernon Inc	1135 Gambier Road Mount Vernon, OH 43050

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on the facility Legionella Environmental Assessment, the Legionella plan and monitoring process, and interview, the facility failed to accurately complete the assessment and follow the plan for monitoring to minimize the risk of Legionella in the water system. This had the potential to affect all 19 residents. The facility census was 19. Findings include: Review of the Legionella Environmental Assessment Form (no date) revealed the facility did not have a whirlpool spa, hot, or hydrotherapy spa on the facility premises. The form also revealed the facility had a water safety plan but did not indicate if the facility ever tested for Legionella in water samples. The source of water used by the facility was municipal water but there was no documentation of how the municipal water was disinfected or if the treatment of the water had changed within the last year. The assessment also revealed there were thermostatic mixing valves used but no documentation where they were located. It was documented that the hot water temperatures were measured by the facility at the points of use, but the lowest hot water temperature was not documented. Review of the facility Legionella monitoring process revealed the hot water temperatures would be checked weekly on each hall and the hot water heaters would also be checked weekly. Review of the water temperature logs revealed water temperatures on each hall were checked in 2024, on 05/07/25 and again on 01/23/26. Water heater temperatures were documented as being checked monthly but there was not day or year documented on the form. An interview on 01/29/26 at 8:04 A.M. with Maintenance Director #102 revealed he had started working at the facility two weeks ago. Maintenance Director #102 verified that the Legionella binder had documentation from 2024 through 2026 and he had provided the surveyor with all the documentation he had available. Maintenance Director #102 verified the facility had a whirlpool tub and the Legionella Environmental Assessment Form was incorrect and incomplete. He also verified there was no documentation of the water temperatures being checked weekly as stated in the monitoring process.

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the Facility Assessment, personnel record review, and interview, the facility failed to provide dementia training to staff upon hire. This had the potential to affect all residents residing in the facility. The facility census was 19. Findings include: Review of the facility's Facility assessment dated [DATE] included under staff training, education and competencies that training would be provided on hire and annually on caring for residents with dementia, Alzheimer's and cognitive impairments as well as implementing non-pharmacological interventions.Review of the personnel record for Certified Nursing Assistant (CNA) #125 revealed a hire date of 12/11/25 with no documentation of dementia training.Review of the personnel record for CNA #120 revealed a hire date of 12/31/25 with no documentation of dementia training.Review of the personnel record for Social Services Designee (SSD) #141 revealed a hire date of 02/25/25 with no documentation of dementia training.Review of the personnel record for Maintenance Director (MD) #102 revealed a hire date of 01/13/26 with no documentation of dementia training.Interview on 01/28/26 at 3:50 P.M. with Human Resource Director (HR) #142 revealed that dementia training is done annually when it populates into the internet training modules.Interview on 01/29/26 at 9:24 A.M. with Director of Nursing (DON) #100 revealed DON #100 identified ten residents (#4, #5, #6, #8, #9, #10, #12, #15, #16, and #21) who had a diagnosis of dementia that resided in the facility.Interview on 01/29/26 at 2:00 P.M. with HR #142 identified 11 staff (Registered Nurse (RN) #115, CNA #120, CNA #125, Licensed Practical Nurse (LPN) #126, CNA #116, Activities Director #105, Activities Aide #130, SSD #141, Dietary Aide #121 and MD #102 as being hired within the last year.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the Facility Assessment, personnel record review, and interview, the facility failed to provide behavioral health training upon hire. This had the potential to affect all residents residing in the facility. The facility census was 19. Findings include: Review of the facility's Facility assessment dated [DATE] included under staff training, education and competencies that training would be provided on hire and annually on caring for residents with mental and psychosocial disorders, as well as caring for residents with a history of trauma and/or post-traumatic stress disorder and implementing non-pharmacological interventions.Review of the personnel record for Certified Nursing Assistant (CNA) #125 revealed a hire date of 12/11/25 with no documentation of behavioral training.Review of the personnel record for CNA #120 revealed a hire date of 12/31/25 with no documentation of behavioral training.Review of the personnel record for Social Services Designee (SSD) #141 revealed a hire date of 02/25/25 with no documentation of behavioral training.Review of personnel record for Maintenance Director (MD) #102 revealed a hire date of 01/13/26 with no documentation of behavioral training.Interview on 01/28/26 at 3:50 P.M. with Human Resource Director (HR) #142 revealed that behavior training is done annually when it populates into the internet training modules.Interview on 01/29/26 at 9:24 A.M. with Director of Nursing (DON) #100 revealed DON #100 identified six residents (#5, #6, #10, #11, #13, and #17) who have behaviors that currently reside in the facility.Interview on 01/29/26 at 2:00 P.M. with HR #142 identified 11 staff (Registered Nurse (RN) #115, CNA #120, CNA #125, Licensed Practical Nurse (LPN) #126, CNA #116, Activities Director #105, Activities Aide #130, SSD #141, Dietary Aide #121 and MD #102 as being hired within the last year.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and facility policy review, the facility failed to ensure as needed (PRN) medication orders for psychotropic medications were limited to 14 days or that the facility physician justified in the medical record continued use of such medications. This affected one resident (#12) of six residents reviewed for unnecessary medications. The facility identified three residents (#2, #10 and #12) as receiving PRN psychotropic medications. The facility census was 19.Findings include: Review of the medical record for Resident #12 revealed an admission date of 09/07/23 with diagnoses including diabetes mellitus, anxiety, and major depressive disorder.Review of the current physician ' s orders revealed that Resident #12 was prescribed 0.5 milligrams (mg) of Lorazepam (an antianxiety medication) by mouth every four hours as needed (PRN) for agitation and anxiety on 12/24/25 with no stop date.Review of the MDS 3.0 quarterly assessment dated [DATE] revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 02, indicating the resident was severely cognitively impaired. Review of the medication administration record (MAR) for January 2026 to date revealed Resident #12 did not receive any PRN doses of Lorazepam.Review of both the electronic and hard chart revealed no other evidence the Resident #12's attending physician documented rationale for continued use of the PRN Lorazepam beyond 14 days as required.Interview on 01/29/26 at 10:07 A.M. with the Director of Nursing (DON) verified that no rationale was documented in Resident #12's medical record for the continued use of the PRN Lorazepam. The DON verified that Resident #12's physician discontinued the PRN Lorazepam as of this date (01/29/26).Review of the undated facility policy titled, Psychotropic Management Policy revealed any as needed (PRN) use of a psychotropic was limited to 14 days and required that the prescriber evaluate the resident for appropriateness prior to renewal.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to code resident Minimum Data Set (MDS) assessments accurately. This affected two residents (#12 and #21) of 18 sampled residents reviewed for accuracy of MDS assessments. The facility census was 19.Findings include: 1. Review of the medical record for Resident #12 revealed an admission date of 09/07/23 with diagnoses including diabetes mellitus, anxiety, and major depressive disorder. Review of the physician's orders revealed Resident #12 was admitted to hospice services on 06/23/25 and remained on hospice services. Review of the MDS 3.0 quarterly assessment dated [DATE] revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 02, indicating the resident was severely cognitively impaired. Resident #12 was recorded as not receiving hospice services during the look back period. Interview on 01/28/26 at 3:50 P.M. with Corporate MDS Nurse #201 revealed Resident #12 should have been marked as being on hospice on the quarterly MDS assessment dated [DATE]. 2. Review of the medical record revealed Resident #21 was admitted on [DATE] with diagnoses that included Alzheimer's disease, mood disorder, hypertension, osteoporosis, and depression. Continued review of the medical record revealed Resident #21 signed a Hospice Agreement on 09/22/25 while residing at an assisted living facility. Review of the Clinical admission assessment dated [DATE] revealed Resident #21 was admitted with hospice services. Review of Resident #21's baseline care plan dated 01/08/26 revealed Resident #21 received hospice services. Review of Resident #21's physician orders revealed an order dated 01/08/26 which noted Resident #21 received hospice services. Review of the admission MDS assessment dated [DATE] revealed Resident #21 had a severe cognitive impairment. Further review of the MDS revealed in section J, item J1400 noted Resident #21 did not have a condition or chronic disease that may result in a life expectancy of less than six months. An interview on 01/28/26 at 3:55 P.M. Corporate MDS Nurse #201 verified Resident #21 received hospice services and section J1400 of the admission MDS was marked incorrectly.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews, and facility policy review, the facility failed to ensure activities were held where Resident #2 could attend and failed to ensure meaningful activities were provided for Resident #4. This affected two residents (#2 and #4) out of five residents reviewed for activities. The facility census was 19.Findings include: 1. Review of the medical record revealed Resident #2 was admitted on [DATE] with diagnoses that included osteomyelitis of the vertebra, type 2 diabetes, and chronic kidney disease. The activities initial review dated 10/27/25 revealed Resident #2 liked playing her gaming system, gardening, reading, word searches, coloring, watching television, and previously enjoyed attending church every Sunday. Resident #2 was currently bedbound and would be doing activities in her room. The activity participation review revealed Resident #2 was willing to go to group activities when she was feeling better. Review of the modification of the 5-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 was cognitively intact and used a manual wheelchair. The plan of care dated 10/28/25 and revised on 01/28/26 revealed Resident #2 was at risk for alteration in activity participation. Interventions included to identify activities of interest, reassess as indicated, encourage resident to experience and learn new activities, and provide one-on-one as needed. No new interventions were added with the revision on 01/28/26. Review of the group activity participation log from 12/31/25 through 01/27/26 revealed Resident #2 participated in only one social activity on 01/07/26. The self-directed activity participation log from 12/31/25 through 01/27/26 revealed Resident #2's activities included watching television and reading. An interview on 01/27/26 at 9:12 A.M. Resident #2 revealed she enjoyed playing bingo. The resident stated the activities were sometimes held at one of the assisted living facilities located on the same campus. Resident #2 stated she was able to walk with a walker now, but it was too far to walk to the assisted living facility. Review of the activities calendar for January revealed four of the 13 scheduled bingo activities were scheduled to be at the assisted living facility. Two of the 13 scheduled bingo activities revealed there were appointments that Activity Director #105 had to transport residents to. The transportation log revealed on 01/27/26 at 8:15 A.M. Activity Director had a scheduled transportation. The activities calendar revealed on 01/27/26 at 9:30 A.M. a craft was scheduled at the assisted living facility, and at 1:30 P.M. bingo was scheduled at the assisted living facility. Continued review of the activities calendar revealed on 01/28/26 at 9:30 A.M., a craft was scheduled to be held at the assisted living facility. The transportation log revealed Activities Director #105 had a scheduled transportation at 11:30 A.M. The activity calendar revealed on 01/28/26 at 1:30 P.M. resident council was to be held at the assisted living facility. The activity calendar also revealed an ice cream social was scheduled at 3:00 P.M. The transportation log revealed 10 days of scheduled appointments that required Activities Director #105 to transport residents. An interview on 01/29/26 at 1:38 P.M. Activities Director #105 verified that activities were held at the skilled and assisted living facilities and residents, but some of the residents did not like going to another building for the activities. Activities Director #105 verified one of her duties required her to transport residents to appointments. If a resident was scheduled for an appointment, the activity would be canceled or held when she returned to the facility. Activities Director #105 verified in the last 30-days there was only documentation of Resident #2 participating in a group activity one time on 01/07/26. Review of the activities policy dated 8/2023 revealed comprehensive activity evaluations were completed upon admission, routinely, and as needed with a change in condition that affects activity participation. Activities are offered based on the individual preferences and needs of each resident. Activity participation is documented in the medical record. 2. Review of the medical record revealed Resident #4 was admitted on [DATE] with diagnoses that included hemiplegia, multiple sclerosis, dementia, aphasia, and depression. Review of the significant change MDS assessment dated [DATE] revealed Resident #4 had a severe cognitive impairment. The activity (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	group activity participation log from 12/31/25 through 01/27/26 revealed Resident #4 participated in an activity on 01/13/26.The self-directed activity participation log from 12/31/25 through 01/27/26 revealed Resident #4 activities included television and a visitor. Multiple observations on 01/28/26 between 8:57 A.M. and 1:30 P.M. revealed Resident #4 was sitting in the common area and there were no structured activities. An observation on 01/29/26 at 9:44 A.M. revealed Resident #4 was sitting in the common area. The movie Sleeping Beauty was on the television at a low volume. No activity members were present in the common area. An interview on 01/29/26 at 1:38 P.M. with Activities Director #105 verified there was not a staff member present for the movie on 01/29/26. Activities Director #105 verified in the last 30-days there was only documentation of Resident #4 participating in one group activity on 01/13/26. Review of the activities policy dated 8/2023 revealed activities are offered based on the individual preferences and needs of each resident. Activity participation is documented in the medical record.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to serve pureed foods at a smooth consistency for safe swallowing. This affected two residents (#4 and #17) who were ordered pureed diets prepared by the facility's kitchen. The facility census was 19. Findings include: 1. Review of the medical record for Resident #4 revealed an admission date of 05/14/24 with diagnoses including Huntington's Disease, depression, and dysphagia. Review of the physician's orders for January 2026 revealed that Resident #4 was prescribed a regular diet with pureed consistency and thin liquids.Review of the MDS 3.0 quarterly assessment dated [DATE] revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 05, indicating the resident was severely cognitively impaired. Resident #4 was dependent for activities of daily living (ADLs) and required assistance with eating.2. Review of the medical record for Resident #17 revealed an admission date of 12/20/23 with diagnoses including multiple sclerosis, depression, and dysphagia.Review of the MDS 3.0 quarterly assessment dated [DATE] revealed Resident #17 had not been assessed for a BIMS. Resident #17 was dependent for activities of daily living (ADLs) and required supervision and partial assistance with meals. Review of the physician's orders for January 2026 revealed that Resident #4 was prescribed a regular diet with pureed consistency and thin liquids.Observation of lunch service in the dining room on 01/29/26 at 11:36 A.M. revealed Resident #4 and Resident #17 received early trays. Observation of Resident #4's lunch revealed that the spaghetti with meat sauce appeared to have pieces of pasta in it. Observation of Resident #17's lunch revealed the pureed spaghetti and meat sauce also had pieces of pasta in it.Observation and interview on 01/29/26 at 11:37 A.M. with Dietary Manager #129 revealed there was pureed spaghetti and meat sauce in a pan on the steam table. DM #129 verified that the spaghetti and meat sauce appeared to have pieces of pasta in it and taste test verified that the spaghetti and meat sauce was not pureed to a smooth consistency. DM #129 stated that the cook who prepared the puree was nervous and would need to be retrained. Review of the undated facility diet protocol titled, Dysphagia 1/Puree Diet, revealed that pasta should be blenderized to a smooth homogenous consistency.