STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366418	A. Building B. Wing	01/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dublin Post Acute	4075 West Dublin-Granville Road Dublin, OH 43017

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, interviews, standards of care, and policy review, the facility failed to have adequate linens available for resident use. This had the potential to affect all 24 residents located on the first floor. The facility census was 65.Findings include: An interview on 01/12/26 at 11:39 A.M. with Resident #34 (resides on the first floor of the facility) revealed there were not enough towels and washcloths for residents to use to be showered as scheduled. An observation on 01/14/26 at 10:14 A.M. revealed the room on the first floor where linens were kept had 14 bath towels, no washcloths, no bed pads, and no fitted sheets. At the time of the observation, Certified Nursing Assistant (CNA) #279 verified this was the only area clean linens were kept on the first floor. CNA #279 stated the staff could go to the laundry room to see if there were clean linens there. An observation on 01/14/26 at 10:21 A.M. of the laundry room revealed there were no dirty linens waiting to be washed and there was only one washer with items being washed. There were eight fitted sheets, eight bed pads, 12 towels, and 17 washcloths washed and folded in the laundry room. An interview on 01/14/26 at 10:32 A.M. with Housekeeping Supervisor (HS) #308 revealed he had recently put out 300 towels and many washcloths. HS #308 verified the staff reported there were not enough linens to provide care for the residents. HS #308 stated that some of the items could be thrown away but a lot of times the extra linen was found in resident rooms. HS #308 stated the CNA's took large amounts of linens to resident rooms and would leave the unused linens in resident rooms. HS #308 verified the staff had complained about not having enough linen and that was why extra linens were recently put out in the clean linen rooms located on the first and second floor. On 01/14/26 at 1:29 P.M. a resident council meeting was held. Residents #10 and Resident #59 (residing on the first floor) revealed showers could not be done because there were no towels. There have also been times when clean linens cannot be put on the beds because there were no fitted sheets. Resident #59 also stated she was given a fitted sheet that was supposed to be clean but smelled of urine and was soiled. Review of the Certified Nursing Assistant (CNA) Standards of Care revealed showers and nail care to be completed as assigned or requested and linens were to be changed on shower days and as needed. Review of the Homelike Environment Policy dated February 2021 revealed the facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized homelike setting. These characteristics include clean bed and bath linens that are in good condition. This deficiency represents non-compliance investigated under Complaint Number 2594008

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff and resident interview, and policy review the facility failed to complete initial care plan conferences and quarterly care plan conferences for residents and responsible parties as required. This affected seven residents (#4, #7, #13, #26, #27, #78, and #114) of 24 residents reviews. The facility census was 65.Findings include: 1.Review of Resident #114's medical record revealed he was admitted to the facility on [DATE]. Diagnoses included moderate protein malnutrition, cystic fibrosis, ALS, anxiety, gastrostomy, chronic pain syndrome, major depression and functional quadriplegia. Review of the quarterly minimum data set assessment dated [DATE] revealed his cognition was intact. He was dependent on staff for eating, oral hygiene, toileting, shower/bathing, dressing, personal hygiene and turning and repositioning. The resident was frequently incontinent of urine and always incontinent of bowel. Review of the care conferences revealed they were completed on 02/10/25 and not again until 10/15/25. On 01/15/26 at 8:59 A.M. interview with Social Service Director #264 verified the Care conferences were not held quarterly for Resident #114. 2. Review of Resident #7's medical record revealed she was admitted to the facility on [DATE]. The resident's diagnoses included diabetes, morbid obesity, adult failure to thrive, chronic obstructive pulmonary disease, chronic resp failure, asthma, schizoaffective disorder, anxiety, depression, personality disorder and PTSD. Review of the quarterly minimum data set assessment dated [DATE] revealed the resident's cognition was intact. She required set up or clean up assistance for eating, independent with oral hygiene, toileting, dressing and personal hygiene . Further review revealed no documented evidence of plan of care conferences for Resident #7. On 01/15/26 at 8:59 A.M. interview with Social Service Director #264 verified the care conferences were not held quarterly for Resident #7. 3. Record review revealed Resident #27 was admitted to the facility on [DATE]. Diagnoses included protein calorie malnutrition, chronic obstructive pulmonary disorder, peripheral vascular disease, and Atherosclerosis of arteries of the left leg with ulceration of other part of left lower leg. Review of the quarterly MDS dated [DATE] revealed her cognition was intact, she required set up or clean up assistance for eating, dependent for oral hygiene, toileting, shower/bathing, dressing, personal hygiene. and turning and repositioning. Review of the care conferences revealed care conferences were completed on 02/05/25 and 04/11/25 for Resident #27. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/15/26 at 8:59 A.M. interview with Social Service Director #264 verified the plan of care meetings were not completed quarterly for Resident #27. Review of the Patient Care Conferences policy, not dated, revealed patient care conferences will be held within seven days of admission, when there has been a significant change and quarterly there after. 4. Review of the medical record revealed Resident #13 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included type 2 diabetes, acquired absence of right leg below knee amputation, moderate protein-calorie malnutrition, and chronic kidney disease. The 5-day MDS assessment dated [DATE] revealed Resident #13 was cognitively intact. Review of the medical record revealed no evidence of care conferences being held with Resident #13 and/or responsible party. An interview on 01/12/26 at 10:00 A.M. with Resident #13 revealed they had not attended any care conferences. An interview on 01/15/26 at 10:20 A.M. Social Service Director #264 verified no care conferences had been held with Resident #13. Social Service Director #264 stated care conferences were not done because Resident #13 had inappropriate sexual behaviors and Resident #13's family could not be reached. Review of the care conference policy (no date) revealed the interdisciplinary team, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The resident is informed of his or her right to participate in his or her treatment and provided advance notice of care planning conferences. If the participation of the resident and his/her representative in developing the resident's care plan is determined to not be practicable, an explanation is documented in the resident's medical record. The explanation should include what steps were taken to include the resident or representative in the process. The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals are documented in the resident's clinical record in accordance with established policies. 5. Review of the medical record revealed Resident #4 was admitted on [DATE] acute on chronic diastolic heart failure, ulcer of anus and rectum, and type 2 diabetes, An admission care conference was held on 06/30/25. Notes from the care conference revealed Resident #4 wanted to return home and the resident's wife was currently looking for another place to live due to steps at the current home. Resident #4 requested that her wife not be notified of the care conference and the resident's wishes were honored. The quarterly MDS dated [DATE] revealed Resident #4 was cognitively intact. An interview on 01/15/26 at 10:20 A.M. Social Service Director #264 verified quarterly care conferences had not been completed for Resident #4. Social Service Director #264 stated the care conferences had not been completed because Resident #4's wife lived in another town. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 01/15/26 at 11:54 A.M. Resident #4 stated they were not aware of any care conferences being held. Review of the care conference policy (no date) revealed the interdisciplinary team, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The resident is informed of his or her right to participate in his or her treatment and provided advance notice of care planning conferences. If the participation of the resident and his/her representative in developing the resident's care plan is determined to not be practicable, an explanation is documented in the resident's medical record. The explanation should include what steps were taken to include the resident or representative in the process. The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals are documented in the resident's clinical record in accordance with established policies. 6. Review of the medical record revealed Resident #78 was admitted on [DATE] and discharged on 04/23/25 with malignant carcinoid tumor of the stomach, severe protein-calorie malnutrition, type 2 diabetes, and vascular dementia. The medical record revealed Resident #78's son was listed as emergency contact. The 5-day admission MDS dated [DATE] revealed the resident had severe cognitive impairment. Review of the medical record revealed no evidence of an initial care conference being held with Resident #78 or the responsible party. An interview on 01/15/26 at 10:20 A.M. Social Service Director #264 verified there was no evidence of an initial care conference being done with Resident #78 or the responsible party. Social Service Director #264 stated she was unsure why the care conference was not done. 7. Review of the medical record for Resident #26 revealed an admission date of 06/06/2025. Diagnoses included acute and chronic respiratory failure with hypoxia, acute and chronic respiratory failure with hypercapnia, obstructive sleep apnea, and morbid obesity with alveolar hypoventilation. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated the resident had intact cognition (BIMS 15) and no significant impairments to upper or lower extremity function, but required set-up assistance for eating and oral hygiene and maximum or dependent assistance for other ADLs. Additional documentation that the resident rejected care 1–3 days. Review of the medical record for Resident #26 revealed no indication that a care conference had been conducted or attempted. Interview on 01/12/26 at 4:28 PM with Resident #26 revealed that he was not being asked to participate in care plan meetings. The resident stated he wanted to go home and did not like the social work interactions, indicating he had no opportunity to engage in the care planning process. Interview on 01/15/26 at 9:00 AM with Social Work Director #264,, confirmed that while quarterly care conferences are part of facility policy, there was no documentation of a care conference for Resident #26. She stated that she had spoken with the resident in July 2025 about a potential care conference but there was no written documentation of that discussion, and no subsequent attempts were made to schedule or conduct any care conferences for this resident. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Care Plans, Comprehensive Person-Centered (version 2.0, revised March 2022) revealed that care conferences support resident participation in care plan development and updates. Residents have the right to identify participants, request meetings or revisions, establish goals and outcomes, determine care details, receive planned services, and sign the plan after significant changes, with refusals documented in the record. The facility provides advance notice of conferences and informs residents of participation rights, documenting explanations if involvement is impracticable. Conferences are held for significant condition changes, unmet outcomes, hospital readmissions, or quarterly MDS assessments to ensure person-centered revisions incorporating preferences, strengths, and specialized needs. This deficiency represents non-compliance investigated under Complaint Number 1350535.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, policy review, and staff interview, the facility failed to ensure activities of daily living (ADL's) for dependent residents were completed. This affected three residents (#7, #26 and #65) of four residents reviewed for ADL care. The census was 65. Findings include: 1. Review of Resident #7's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included diabetes, morbid obesity, adult failure to thrive, chronic obstructive pulmonary disease, chronic resp failure, asthma, schizoaffective disorder, anxiety, depression, personality disorder and PTSD. Review of the quarterly minimum data set assessment dated [DATE] revealed her cognition was intact. She required set up or clean up assistance for eating, independent with oral hygiene, toileting, dressing and personal hygiene. Review of resident documented showers revealed no shower or bath documented between 11/12/25 and 11/19/25, and between 12/10/25 and 12/21/25. On 01/12/26 at 8:55 A.M. interview of the Director of Nursing (DON) confirmed no evidence Resident #7 received showers twice a week. 2. Review of Resident #65's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included dementia, bipolar disorder, depression, anxiety, peripheral vascular disease, diabetes and chronic kidney disease. Review of the quarterly minimum data set assessment (MDS) 12/10/25 revealed her cognition was not intact, she was dependent on staff for personal hygiene. Review of the showers revealed Resident #65 received shower/baths in November 2025 on 11/09/25, 11/20/25. 11/23/25, 11/27/25 and 11/30/25. For December 2025, Resident #65 received showers on 12/04/25, 12/07/25, 12/11/25, 12/14/25, 12/18/25 and 12/21/25 and in January 2026 Resident #65 received showers on 01/04/26 and 01/11/26 On 01/21/26 at 11:14 A.M. verified with the Director of Nursing showers were not completed twice a week for Resident #65. 3. Review of the medical record for Resident #26 revealed an admission date of 06/06/25. Diagnoses included acute and chronic respiratory failure with hypoxia, acute and chronic respiratory failure with hypercapnia, obstructive sleep apnea, and morbid obesity with alveolar hypoventilation. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact (BIMS 15) with a mood score of 11. The assessment noted the resident rejected care 1–3 days weekly and required dependent assistance of staff for transfers, bed mobility, toileting, and showering. The resident used a wheelchair and required set-up assistance for eating and oral hygiene, with maximum assistance needed for personal hygiene tasks, including bathing. Review of the plan of care dated 06/09/25 and revised 06/12/25 revealed the resident was at risk for ADL decline due to recent hospitalization, respiratory failure, obstructive sleep apnea, and (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	morbid obesity. Interventions included providing maximum assistance with bathing per schedule and resident preference, total dependent assistance with bed mobility, and nail care to be completed on shower days or as needed, with reporting of changes to the nurse. The plan specified that nails should be trimmed by the nurse for diabetic residents. Review of bed bath and nail care documentation from 11/11/25 through 01/13/26 consistently indicated N/A for nail care, reflecting that staff did not attempt nail care when the resident refused or that care was not completed. On multiple scheduled shower and bed bath days—including 11/04/2025, 11/08/2025, 11/18/2025, 12/13/2025, and 12/23/2025—there was no documentation indicating bathing or nail care was provided. Only 12/06/2025 included a completed shower sheet with a skin check, which noted no new skin conditions but provided no indication of nail care. Interview and observation on 01/12/26 at 4:19 PM, the resident reported and was observed with long nails with brown debris underneath, yellowing on his fingers, and requested a nail clipper, which he had not received. He stated he had not left bed since July and that his nails had been uncared for during that time. Interview on 01/14/26 at approximately 8:36 A.M. with Director of Nursing confirmed that documentation of N/A for nail care indicated staff did not attempt nail care. He further confirmed that based on the bathing task records, the resident had not received nail care and that staff had not attempted fingernail cleaning or nail trimming during the reviewed period. Observation on 01/14/26 at approximately 9:22 A.M. revealed the resident's thumbnail was visibly long, and the resident's fingernails contained a brown substance underneath the nails. Interview on 01/14/26 at approximately 9:22 A.M. with Licensed Practical Nurse (LPN) #224 confirmed the resident's thumbnail was long and that his fingernails were visibly soiled. She stated nail care was typically provided on shower days and acknowledged that if the resident refused bathing, nail care was not completed. She was unable to identify when the resident last received fingernail cleaning or nail trimming. Review of the facility policy titled Activities of Daily Living (ADL), Supporting (version 1.0, revised March 2018) revealed that residents receive care and services to maintain or improve bathing and other ADLs unless decline is unavoidable due to debilitating disease with expected loss, acute disability while receiving restorative care, or informed refusal after risk/benefit discussion, alternatives offered, and documentation. Diagnosis alone does not justify decline. For residents unable to bathe independently, staff provide assistance with bathing, grooming, dressing, and oral hygiene per the care plan and with consent. Interventions match assessed needs, preferences, goals, and standards, including pain management, depression treatment, and ongoing monitoring. For cognitively impaired residents resisting bathing, staff identify causes and try different approaches, times, or staff. Bathing ability is measured via MDS definitions (Independent, Supervision, Limited Assistance, Extensive Assistance, Total Dependence) against the assessment reference date, with decline/improvement evaluated and revisions made as needed. This deficiency represents non-compliance investigated under Complaint Number 2708970.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, resident interview, staff interview, and facility policy review, the facility failed to complete ordered treatments for Resident #7, failed to properly assess and address Resident #9's skin impairment to the toe, failed to initiate Resident #19's physician order dated 12/31/25 until 01/03/26, failed to ensure ordered TED hose were applied for Resident #24 for three days, failed to transcribe and implement discharge orders from the after visit summary (AVS) for Resident #25, failed to properly treat Resident #26's irritated skin as ordered, failed to complete ordered treatment to the buttocks for Resident #61, and failed to complete ordered treatment for Resident #83. This affected eight residents (#7, #9, #19, #24, #25, #26, #61, #83) out of 32 residents reviewed in the sample. The facility census was 65.Findings include:1.Review of the medical record for Resident #26 revealed an admission date of 06/06/25. Diagnoses included acute and chronic respiratory failure with hypoxia, acute and chronic respiratory failure with hypercapnia, obstructive sleep apnea, and morbid obesity with alveolar hypoventilation. Review of the plan of care dated 06/09/25 and revised 06/12/25 identified interventions requiring staff to provide bathing per schedule and preference, including total dependent assistance with bed mobility and application of topical medications as ordered, such as Nystatin powder for the right neck fold to be applied twice daily and as needed. Review of the physician orders included right neck fold wash with soap and water, pat dry, apply Nystatin powder twice daily and as needed for 7 days (Active 09/12/25). Additionally, apply barrier cream after each incontinence episode (Active 06/06/25). Review of the medication administration record (MAR) and treatment administration record (TAR) revealed the order for Nystatin powder was active 09/12/25, yet there was no documentation that the medication had been administered from September 2025 through 01/14/26, except for a brief 9/12/25–9/19/25 period. Bathing documentation indicated multiple days, including 11/04/25, 11/08/25, 11/18/25, 12/13/25, and 12/23/25, with no indication that the resident received a bed bath or topical application as ordered. Shower sheets were inconsistently completed, with only 12/06/25 documented, showing no skin issues and no indication of treatment or monitoring for the neck fold. Observation on 01/12/26 at 4:20 PM revealed the resident had raw, red, and painful skin under the neck fold, and he stated that staff were not addressing the area during bed baths or with creams. Interview on 01/14/26 at 7:55 AM, Licensed Practical Nurse (LPN) #224 stated she had noticed redness under the resident's neck a couple of weeks prior, had not observed any improvement, and confirmed that the Nystatin powder had not been administered since September 2025. She administered the Nystatin after discussion with the surveyor, and stated she would notify the night nurse and nurse practitioner (NP) regarding ongoing care. Interview on 01/14/26 at 8:06 AM, Certified Nursing Assistant (CNA) #252 reported that he had been providing bed baths for the resident and had noticed the redness under the neck for 2–3 weeks but had not reported or documented it. Interview on 01/14/26 at 8:36 AM, Director of Nursing (DON) confirmed that the Resident #26 had not received proper topical treatment for his neck fold. He also noted that shower sheets were inconsistently completed, contributing to discrepancies in documentation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 01/14/26 at 9:22 AM, licensed practical nurse (LPN) #224 confirmed that the resident's neck fold was very red and painful. She applied the Nystatin powder that morning after surveyor intervention, and the resident reported that this irritation had been present for months. 2. Review of the medical record for Resident #25 revealed an admission date of 10/14/25. Diagnoses included other acute osteomyelitis of the right ankle and foot, type 2 diabetes mellitus with foot ulcer, acquired absence of other right toe(s) status post right toe amputation, cellulitis of the limb, lymphedema, edema, and other reduced mobility. Review of the 5-day Medicare MDS dated [DATE] identified the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15, had impairment of one lower extremity, was dependent for lower extremity dressing and footwear, and had open lesions on the foot. Review of the Braden assessments dated 10/14/25 and 10/29/25 reflected the resident was at risk for skin breakdown with scores of 15 and 16. Review of physician orders identified multiple wound care and compression treatment orders for the right great toe amputation site and left lower extremity, with several active and discontinued orders between 10/29/25 and 01/09/26. Orders for the right great toe amputation site included cleansing the wound with normal saline or wound cleanser, patting dry, and packing with various products, including Betadine-soaked gauze (10/29/25–11/11/25), collagen (11/26/25–12/02/25), silver alginate (12/03/25–12/06/25, 12/07/25–01/08/26), and combinations thereof, covered with ABD pads and secured with Kerlix. These orders specified treatment frequencies ranging from every shift daily to every Monday, Wednesday, and Friday, depending on the order and product used. Orders for the left lower extremity included application of Tubigrip and Ace wraps (11/25/25–active) and daily Kerlix and Coban layering with specific spiral technique instructions (discontinued 10/29/25), intended for compression and lymphedema management. Review of the MAR/TAR revealed the right great toe amputation site treatment ordered to be completed daily was not documented as provided on multiple dates including 12/09/25, 12/11/25, 12/14/25, 12/17/25, 12/19/25, 12/21/25, 12/23/25, and 12/31/25. The TAR indicated the resident was out of the facility on 01/03/26 and treatment was not provided, however there was no corresponding progress note to support that the resident was out of the building on that date. Review of wound assessments revealed no documented measurements, wound status, or indication of improvement, decline, or stability of the right great toe amputation site. A note dated 11/11/25 stated the wound was closed, however wound care orders remained active and continued to require treatment without documentation supporting reassessment or discontinuation. Review of hospital and wound clinic after visit summaries revealed multiple discrepancies between wound clinic instructions and the facility's physician orders. The AVS dated 10/20/25 instructed daily dressing changes for the right great toe amputation site, but the facility order at that time was every Monday, Wednesday, and Friday. The same AVS also directed application of an Ace wrap to the affected leg(s) from toes to knee with 50% stretch and overlap, to be reapplied as needed during the day and removed at bedtime, yet the facility orders did not reflect this until 10/29/25 and then only for a single day. The AVS dated 10/27/25 again directed daily dressing changes for the right great toe and application of a 3M Coban 2 multilayer compression wrap to the left leg, neither of which were included in the facility's orders. The AVS dated 11/04/25 instructed daily right great toe dressing changes and left leg multilayer compression wrap, but these instructions were not reflected in (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the facility's orders or the TAR, and no documentation verified that treatments were completed. No AVS documentation was available for wound clinic visits between 11/04/25 and 12/01/25, resulting in a lack of updates on wound status or care instructions. The AVS dated 12/01/25 directed daily dressing changes for the right great toe and application of Coban wrap to the right lower leg, but these instructions did not match the orders in PCC. The AVS dated 12/08/2025 included daily dressing changes for the right great toe and multilayer compression wrap to the left leg, which were not reflected in facility orders. The AVS dated 12/29/25 instructed daily right great toe dressing changes and application of medium Spandagrip and Ace wrap to the left leg from toes to just below the knee, but again these directions did not match the facility's orders, and there was no documentation of treatment completion. Additionally, after visit summaries for 01/07/26 and 01/14/26 were not present in the medical record, leaving gaps in clinical guidance and updates regarding the right great toe amputation wound and bilateral lower extremity compression. Review of a nurse's progress note dated 11/10/25 indicated the resident returned from a doctor appointment with new wound orders and directed staff to refer to the MAR and TAR, however the corresponding after visit summary was not present and no updated orders were identified. Interview on 01/14/26 at 3:45 PM with Registered Nurse (RN) #237 revealed that if the wound nurse completes dressing changes, the wound nurse does not always mark the treatment as completed on the TAR. Interview on 01/14/26 at 3:52 PM with Wound Nurse #254 revealed she was unsure why dressing changes were blank on the TAR and confirmed she could not provide evidence that the dressing changes were completed appropriately. She stated that if wound care was completed, it should be marked on the TAR. She also could not confirm the resident was out of the facility on 01/03/26. Interview on 01/15/26 at 10:30 AM with Wound Nurse #254 revealed the resident attends weekly wound clinic appointments at Ohio Health and that she does not routinely receive or request ongoing information from those visits unless there is a treatment change. She confirmed she was unsure of the current status of the resident's right great toe wound and that the AVS' did not include updates on how the wound was progressing. Interview on 01/15/26 at 11:09 AM with Wound Nurse #254 revealed she reviews after visit summaries only for care instruction changes and confirmed there was no documentation in the record describing wound measurements or wound progression. Interview on 01/15/26 at 11:41 AM with Resident #25 revealed he does not usually have ace wraps on his legs and stated that only the wound nurses have been told to wrap his legs. Observation at that time revealed the resident did not have ace wraps applied despite active physician orders. Interview on 01/15/26 at 11:49 AM with Licensed Practical Nurse (LPN) #318 confirmed the ace wraps were not in place and confirmed they should have been applied due to the resident's bilateral lower extremity lymphedema. Interview on 01/15/26 at 4:11 PM with the Director of Nursing confirmed that wound care and compression orders were not being completed appropriately. Interview on 01/20/26 at 7:57 AM with Wound Nurse #254 confirmed that after visit summary orders did not match the physician orders in the facility system. She confirmed that after visit summaries (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366418	A. Building B. Wing	01/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dublin Post Acute	4075 West Dublin-Granville Road Dublin, OH 43017

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	from 11/04/25 through 12/01/25 could not be located and that after visit summaries for 01/07/26 and 01/14/26 were also missing. She further confirmed there were no wound measurements or wound status updates documented in the medical record and she was unable to state the current condition of the resident's right great toe wound. Observation/interview on 01/20/26 at 10:39 AM with RN #237 revealed the resident was up in a chair without ace wraps applied to either leg despite active physician orders. The resident stated his lymphedema pump treatment had been completed earlier that morning but his legs were not wrapped after the treatment. The nurse applied the ace wraps following surveyor intervention. 3. Review of the medical record for Resident #61 revealed an admission date of 11/28/20. Diagnoses included multiple sclerosis, polyneuropathy in diseases classified elsewhere, anxiety disorder, major depressive disorder, insomnia, auditory hallucinations, other specified dorsopathies of the cervical region, chronic pain syndrome, generalized muscle weakness, other muscle spasm, gastroesophageal reflux disease without esophagitis, vitamin D deficiency, pityriasis versicolor, unspecified exotropia, and weakness. Review of the quarterly MDS dated [DATE] indicated the resident was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15, required maximum assistance for upper extremity dressing and dependent assistance for lower extremity dressing and putting on/off footwear, was dependent for personal hygiene, rolling, sit-to-stand, and transfers, and used a wheelchair for mobility. Review of physician orders identified active orders for the treatment of bilateral buttocks moisture-associated skin damage (MASD) with a topical mixture of zinc oxide 20% dated 11/04/25, triamcinolone 0.1% dated 11/04/25, and terbinafine 1% dated11/05/25, to be applied three times daily. Orders specified cleansing the affected area with soap and water prior to application and maintaining clean, dry skin, with no dressings to be applied. Review of the MAR/TAR revealed multiple missed treatments for December 2025 and January 2026 for all three topical orders for bilateral buttocks MASD: Zinc Oxide 20% External Paste: Missing administrations included morning and afternoon treatments on 12/05/25–12/07/25 and 12/09/25, evening treatments on 12/10/25, 12/17/25, 12/19/25, 12/20/25, 12/24/25, and 12/26/25, all three treatments on 12/27/25, evening treatments on 12/28/25–12/31/25, evening treatment on 01/01/26, all three treatments on 01/02/26, evening treatments on 01/05/26–01/11/26, and the morning treatment on 01/20/26. Triamcinolone Acetonide 0.1% External Cream: Missing administrations included morning and afternoon treatments on 12/05/25–12/07/25 and 12/09/25, evening treatments on 12/10/25, 12/17/25, 12/19/25, 12/20/25, 12/24/25, and 12/26/25, all three treatments on 12/27/25, evening treatments on 12/28/25–12/31/25, evening treatment on 01/01/26, all three treatments on 01/02/26, evening treatments on 01/05/26–01/11/26, and the morning treatment on 01/20/26. Terbinafine HCl 1% External Cream: Missing administrations included morning and afternoon treatments on 12/05/25–12/07/25 and 12/09/25, evening treatments on 12/10/25, 12/17/25, 12/19/25, 12/20/25, 12/24/25, and 12/26/25, all three treatments on 12/27/25, evening treatments on 12/28/25–12/31/25, evening treatment on 01/01/26, all three treatments on 01/02/26, evening treatments on 01/05/26–01/11/26, and the morning treatment on 01/20/26. (continued on next page)

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	366418	A. Building B. Wing	01/26/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of progress notes indicated ongoing MASD with care planning in place; however, repeated treatments for all three orders were not documented as completed. Review of prior skin assessments and progress notes from 12/15/25 and 12/29/25 confirmed the presence of MASD on the right gluteus, with staff education and care planning in place for moisture control, incontinence management, turning/repositioning, and topical treatment. Interview on 01/12/26 at 3:12 PM with Resident #61 revealed she stated that when she is changed, staff are supposed to apply cream to her coccyx, but treatments were not being completed as ordered. Interview on 01/20/26 at 1:17 PM with the Director of Nursing (DON) confirmed that there was no documentation explaining the missed treatments for the buttocks cream, and no interventions had been implemented to ensure compliance with the orders. 4. Review of Resident #19's medical record revealed he was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, diabetes, anxiety, depression, absence of the right great toe and peripheral vascular disease. Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed his cognition was intact. He requires supervision or touching assistance for eating, oral hygiene, toileting, shower/bathing, dressing, personal hygiene and independent for turning and repositioning. Occasionally incontinent of urine and always continent of bowel. Review of the progress notes on 12/31/25 revealed a new skin issue, location: left dorsum first interdigital space (foot). Diabetic ulceration (new wound). Wound acquired in house. Exact date 12/30/25, staged by healthcare provider. Length 5.49 centimeters (cm) by width 3.96 cm by 0 depth. Area (cm2) 16.94. Cleanse with normal saline, iodine moistened gauze and ABD pad and kerlix wrap. Further review of physician orders revealed the treatment order was not written until 01/02/26 and review of the treatment record revealed it was not documented as completed until 01/03/26. On 01/15/26 at 11:07 A.M interview with Registered Nurse (RN) #254 verified the order for Resident #19's diabetic ulcer was not transcribed until 01/02/26 and not documented as completed until 01/03/26 (three days after the treatment was originally ordered). 5. Review of Resident #24's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included acute kidney failure, severe protein calorie malnutrition, COPD, A FIB, depression, anxiety and weight loss. Review of the quarterly MDS dated [DATE] revealed her cognition is intact, she is independent with eating, oral hygiene, toileting, shower/bathing, dressing and personal hygiene. Is occasionally incontinent of urine and continent of bowel. Review of the physician orders revealed on 01/09/26 an order for knee high ted hose (compression stockings) to both legs one time a day for swelling and remove per schedule. Review of the treatment record revealed the compression stockings were to be applied on dayshift. Observation on 01/12/26 at 3:29 P.M., 01/13/26 at 2:10 P.M., 01/14/26 at 2:22 P.M. and 01/15/26 at 10:45 A.M. revealed Resident #24 was not wearing ted hose. Interview with Licensed Practical Nurse (LPN) #224 on 01/15/26 at 10:46 A.M. verified Resident #24 did not have her ted hose on as ordered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366418	A. Building B. Wing	01/26/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Review of Resident #7's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included diabetes, morbid obesity, adult failure to thrive, chronic obstructive pulmonary disease, chronic resp failure, asthma, schizoaffective disorder, anxiety, depression, personality disorder and PTSD. Review of the quarterly minimum data set assessment dated [DATE] revealed her cognition was intact. She required set up or clean up assistance for eating, independent with oral hygiene, toileting, dressing and personal hygiene. Review of the physician orders revealed a treatment on 09/19/25 to the right groin wound and apply mupirocin ointment, cover with abdominal (ABD) pad two times a day for wound care and on 11/11/25 to the left genital region cleanse with normal saline or wound cleanser, pat dry and apply mupirocin ointment to wound bed, pack wound bed with wet to dry gauze, cover with ABD pad two times a day for wound care. Review of the TAR for December 2025 revealed the treatment to the right groin area was to be completed at 9:00 A.M. and 8:00 P.M. Documentation at 9:00 A.M. revealed the treatment was not documented as completed on 12/05, 12/06, 12/07, 12/09, and 12/27. Documentation for the treatment at 8:00 P.M. revealed the treatment was not documented as completed on 12/10, 12/17, 12/19, 12/20, 12/22, 12/25, 12/26, 12/2712/28, 12/29, 12/30 and 12/31. Review of the treatment record for January 2026 revealed the treatment to the right groin area was to be completed at 9:00 A.M. and 8:00 P.M. Documentation at 9:00 A.M. revealed the treatment was not documented as completed on 01/02. Documentation for the treatment at 8:00 P.M. revealed the treatment was not documented as completed on 01/01, 01/02, 01/05, 01/06, 01/07, 01/08, 01/09, 01/10 and 01/11/26. On 01/21/26 at 11:00 A.M. interview with Registered Nurse #254 verified the missing treatment order for Resident #7's groin wound for December 2025 and January 2026. 7. Medical record review for Resident #9 revealed she was admitted to the facility on [DATE]. Her diagnoses included, obesity, gastro-esophageal reflux disease (GERD) , essential primary hypertension, obstructive sleep apnea, hyperlipidemia, gout, dysphagia, anxiety, diabetes mellitus (DM), peritonitis, insomnia, and malignant neoplasm of the neck. Resident #09 required hospice services. Review of the Minimum Data Set (MDS) assessment for Resident #9 dated 12/12/25 revealed she was mildly cognitively impaired. Resident #9 was dependent on staff for medication administration, and required supervision from staff with eating. Resident #9 required moderate assistance from staff with oral hygiene, toilet use, bathing, upper body dressing, lower body dressing, and personal hygiene. She required maximum assistance from staff with putting on shoes. Review of the MDS assessment revealed Resident #9 required Hospice Services. Review of the progress notes for Resident #9 dated 01/07/26 at 7:34 P.M. revealed a note that stated, no wound noted at resident's left great toe, hospice updated. Further review of the progress notes dated 01/13/26 at 4:05 P.M. revealed a significant change note for Resident #9 and it stated a nursing observation of a reddened skin area of .03x.03x0.0 with no drainage noted with no identification of location. The primary care response recommendations were ABI betadine and leave open to air and a new testing for venous doppler. A late entry note for 01/13/26 at 4:05 P.M. revealed wound nurse was called to Resident #9's room and a reddened area to the left great toe was present and it measured .3x.3x0. Wound Nurse Practitioner (WNP) #515 notified and new orders for betadine every day leave open to air. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366418	A. Building B. Wing	01/26/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the skin assessment for Resident #9 dated created on 01/20/26 for the following dates 12/17/25, 12/24/25, 12/31/25, 01/07/26, and 01/14/26 locked on 01/20/26. Observation on 01/13/26 at 4:02 P.M. with Registered Nurse (RN) #227 revealed Resident #9 had a large round scabbed area about the size of a quarter at the top of her left great toe. Resident #09's left great toe was reddened and had two cracked skin around the large scab that appeared to have two small cracks that were opened around the large scab. Observation revealed RN #227 pushed on the reddened left great toe and observed Resident #9 wince in pain. Resident #9 confirmed the pressure on the toe caused pain. Interview on 01/13/26 at 4:02 P.M. with RN #227 confirmed the progress note in Resident #9's medical record was very confusing. RN #227 stated she could not determine by the note written on 01/07/26 if Resident #9's big toe on her left foot had been assessed. RN #227 confirmed the facility has not had any treatments for Resident #9's great toe on her left foot. RN #227 confirmed Resident #9 does have a large scabbed area on the top of her left great toe and two open cracked skin areas around the scab and the toe was reddened. RN #227 confirmed Resident #9 stated the toe was painful when pressure was applied. Interview on 01/14/26 at 12:34 P.M. with Resident #9's hospice case manager, Registered Nurse (RN) #619 confirmed on 01/06/26 the hospice aide identified a darkened area on Resident #9's left great toe. RN #619 stated a hospice nurse evaluated the toe and identified it as a deep tissue injury (DTI) and notified the facility. RN #619 stated the hospice nurse felt the DTI could have been from Resident #9's shoes. RN #619 stated the facility notified RN #619 on 01/07/26 that Resident #9 did not have any area to the toe and did not recommend a treatment. Review of the order summary report for Resident #9 revealed an order dated 01/13/26 revealed an order for a left lower leg doppler to rule out arterial. An order dated 01/13/26 with a start date 01/14/26 for left great toe treatment: cleanse with normal saline or wound cleanser, pat dry. Paint with betadine, leave open to air every day shift for wound care. Review of the email dated 01/14/26 at 4:29 P.M. to the facility wound nurse (FWN) #254 from the WNP #515 confirmed he assessed Resident #9's left great toe on 01/07/26. WNP #515 confirmed a 100% epithelialized and blanching but fragile area was noted. WNP#515 recommended panting with betadine and leaving open to air and to be re-evaluated. Interview on 01/21/26 at 10:04 A.M. with the Wound Nurse Practitioner (WNP) #515 confirmed he assessed Resident #9's left big toe on 01/07/26 and determined that Resident #9 required preventative measure be taken for Resident #9's discolored large big toe. He confirmed he requested a preventative order be put in place to start on 01/07/26 to paint with betadine and leave open to air. Interview on 01/13/26 at 4:20 P.M. with the FWN #254 confirmed the facility failed to start the preventative order requested on 01/07/26 by WNP #515 to paint Resident #9's great left toe with betadine and leave open to air. Subsequent interview on 01/21/26 at 10:00 A.M. with FWN #254 confirmed the facility failed to have skin assessments completed for Resident #9. FWN #254 confirmed the following skin assessments for Resident #9 were created on 01/20/26 for the following dates 12/17/25, 12/24/25, 12/31/25, 01/07/26, and 01/14/26 locked on 01/20/26. (continued on next page)

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	366418	A. Building B. Wing	01/26/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. Review of the medical record revealed Resident #83 was admitted on [DATE] and discharged on 01/08/26 with diagnoses that included lumbago with sciatica, left side, COVID-19, elevated white blood cell count, acute respiratory failure, bradycardia, hyperlipidemia, and emphysema. The hospital discharge records dated 01/02/26 revealed orders for Resident #83's incision to be left open to air. The skin around the incision was to be washed daily with mild soap and water and patted dry. The admission evaluation/assessment dated [DATE] revealed Resident #83 had an incision to mid back vertebrae that measured 16 centimeters (cm) long and one cm wide. Review of the medication and treatment administration records revealed no evidence of Resident #83's skin around the incision to be washed and dried every day. A plan of care dated 01/12/26 revealed Resident #83 was at risk for skin breakdown/pressure ulcers. Interventions included to administer treatments as ordered and notify the physician and/or responsible party of non-compliance with treatment interventions. An interview on 01/21/26 at 11:16 A.M. the Director of Nursing verified the order to wash and dry the skin around Resident #83's incision every day should have been on the treatment administration record and completed as ordered. This deficiency represents non-compliance investigated under Complaint Number 2708970, 2594008.

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	366418	A. Building B. Wing	01/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - 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 observation, record review, interviews, and policy review, the facility failed to implement a comprehensive and individualized pressure ulcer program to timely identify, treat and/or prevent a decline of pressure ulcers. Actual Harm occurred to one resident (#23), who had been identified at risk for pressure ulcer development and required maximum staff assistance for bed mobility, on 12/10/25 when the facility failed to accurately assess, put a treatment and appropriate interventions in place in a timely manner, and complete treatments as ordered to a pressure ulcer wound to the resident's back that was first identified on 12/08/25 (two days after the resident was admitted to the facility). An outside wound company assessed the area on 12/10/25 and identified the area as a Stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough) pressure ulcer to the center midline upper back that measured two centimeters (cm) long, two cm wide, and 0.01 cm deep. The daily treatment ordered on 12/10/25 was completed on 12/12/25, 12/15/25, 12/16/25, 12/24/25, 12/26/25, 01/05/26, 01/07/26, and 01/12/26, reflecting only eight of 35 days that the treatment was completed. The outside wound company did not assess the area again until 12/31/25. At that time, the area was identified as an Unstageable (full-thickness tissue loss where the wound bed is obscured by dead tissue such as slough) pressure ulcer to upper spine which measured 2.5 cm long and 1 cm wide. Additionally, the facility failed to ensure low air loss mattresses used for pressure ulcer prevention were being used with the recommended pressure settings for two residents (#8 and #61) which placed the residents at risk for more than potential harm that was not actual harm. This affected three (#8, #23, and #61) of six residents reviewed for pressure ulcers. The facility census was 65. Findings include: 1) Review of the medical record revealed Resident #23 was admitted on [DATE] with diagnoses that included a fracture of the right humerus, wedge compression fracture of second lumbar vertebra, multiple fractures of ribs, thrombocytopenia and hypertension. The after-visit summary from the hospital dated 12/06/25 revealed Resident #23 had a displaced comminuted fracture of right humerus. Resident #23 also had Lumbar Kyphoplasty (minimally invasive procedure to fix spinal compression fractures) wound closed with Dermabond glue. The Admission/re-admission Summary note dated 12/07/25 revealed Resident #23 arrived by ambulance and was transferred to the bed with two-person assistance. A head-to-toe assessment was completed. There were bruises and edema (swelling) on both arms and a sling to the resident's right arm due to a fracture. Edema was noted to both legs and both heels were dry. There were no open areas to the heels. The resident had a Stage II open pressure wound with slough on the right upper thigh that measured five centimeters (cm) long and three cm wide. Review of the Baseline Care Plan dated 12/07/25 revealed there was nothing marked under skin integrity (prior and current concerns). The care plan also revealed Resident #23 required substantial/maximal assistance with sitting to lying and lying to sitting on the side of the bed. The Braden Scale Observation assessment dated [DATE] revealed Resident #23 scored a 16 which indicated the resident was at risk for the development of pressure ulcers. There was no documentation that a pressure ulcer plan of care with interventions was developed or implemented to decrease Resident #23's risk for developing pressure ulcers based on the resident's pressure ulcer risk assessment (Resident #23 was identified as at risk). Review of a physician progress note dated 12/08/25 revealed Resident #23 was seen at the hospital from [DATE] through 12/06/25 for a right humerus fracture. The hospital course was complicated by a lumbar compression fracture to L2. Resident #23 underwent kyphoplasty on 12/03/25. Wound documentation dated 12/08/25 by the facility wound nurse, Registered Nurse (RN) #254, revealed Resident #23 had a surgical wound to the spine that was present upon admission. The wound was measured at (continued on next page)

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	366418	A. Building B. Wing	01/26/2026

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F 0686 Level of Harm - Actual harm Residents Affected - Few	15.9 cm long and 18 cm wide. The wound was to be cleansed with normal saline/generic wound cleanser and covered with foam dressing. Review of the outside Wound Company dated 12/10/25 by Nurse Practitioner (NP) #515 revealed Resident #23 presented with an acute pressure ulceration of the center midline upper back. The initial evaluation revealed Resident #23 had a Stage II pressure ulcer to the center midline upper back that measured two cm long, two cm wide, and 0.01 cm deep. There was a moderate amount of serosanguineous (thin, watery, pink or light red fluid) exudate. The wound was to be cleansed with normal saline, and medical grade honey (antibacterial, anti-inflammatory, and antioxidant properties) and calcium alginate (creates a moist healing environment and absorbs exudate) were to be applied and then covered with clean dry dressing every day and as needed. An addendum revealed the wound location was closer to the left upper back. Wound documentation dated 12/10/25 by RN #254 revealed Resident #23 had a Stage II pressure ulcer/injury to lower back. The wound measured 1.84 cm long and 1.59 cm wide. There was a moderate amount of serosanguineous exudate. Review of the plan of care dated 12/10/25 reveled Resident #23 was at risk for skin breakdown/pressure ulcers related to displaced comminuted fracture of shaft of humerus, right arm, and subsequent encounter for fractures with routine healing. Interventions included to administer medication and treatments as ordered, apply barrier cream as indicated, and encourage the resident to float heels, keep the resident's skin clean and notify the physician and/or responsible party of non-compliance with treatment. Further review of the plan of care revealed there were no interventions related to the resident's Stage II pressure ulcer to the upper back. Review of the Treatment Administration Record (TAR) revealed a treatment for Resident #23's upper mid back to be cleansed with normal saline or a wound cleanser, patted dry, medical grade honey, and calcium alginate applied, and covered with an abdominal (ABD) pad and gauze wrap bandage every day for wound care starting on 12/11/25. The treatment was documented as being completed five (12/12/25, 12/15/25, 12/16/25, 12/24/25, and 12/26/25) out of 21 days. There was no documentation of the treatment being completed as needed. The documentation for turning and repositioning revealed there were 11 shifts between 12/07/25 and 01/01/26 that Resident #23 was not turned and repositioned. Review of the 5-day Medicare Minimum Data Set (MDS) dated [DATE] revealed Resident #23 was cognitively intact. The resident was dependent on another person for toileting, bathing, rolling left to right, sitting to lying, lying to sitting, and sitting to standing. Resident #23 was at risk for pressure ulcers and was admitted with a Stage II pressure ulcer (to the resident's right leg) that was present upon admission and a skin tear. Wound documentation dated 12/17/25 by NP #515, from an outside wound company, revealed an evaluation was only completed of Resident #23's right leg. Wound documentation dated 12/17/25 by RN #254 revealed Resident #23 had a Stage II pressure ulcer to lower back. The area was improving and measured 0.5 cm long and 0.5 cm wide. There was a moderate amount of serosanguineous exudate. Review of the Braden Scale Observation assessment dated [DATE] revealed Resident #23 scored 14 which indicated the resident was at moderate risk for the development of pressure ulcers; however, this pressure ulcer risk assessment was not accurate as the resident already had an identified pressure ulcer at this time. Wound documentation dated 12/24/25 by NP #515, from an outside wound company, revealed an evaluation was only completed of Resident #23's lower right leg. Wound documentation dated 12/24/25 by RN #254 revealed Resident #23 had a Stage II pressure ulcer to lower back that was improving and measured 5 cm long and 1.3 cm wide. The wound bed had 80% granulation (healthy, red, bumpy, new tissue) with a moderate amount of serosanguineous exudate. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366418	A. Building B. Wing	01/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dublin Post Acute	4075 West Dublin-Granville Road Dublin, OH 43017

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Braden Scale Observation assessment dated [DATE] revealed Resident #23 scored a 15 which indicated the resident was at risk for the development of a pressure ulcer. Wound documentation dated 12/31/25 by NP #515, from an outside wound company, revealed Resident #23 had an Unstageable (full-thickness tissue loss where the wound bed is obscured by dead tissue such as slough) pressure ulcer to upper spine that measured 2.5 cm long and 1 cm wide. There was a moderate amount of serosanguinous exudate, and the peri wound was ecchymotic (skin discoloration blue/purple/black/brown/yellow). The wound was being evaluated for the first time, and a treatment plan would be established. Debridement was postponed due to high patient discomfort or pain concerns. The resident had mild transient pain during wound assessment. The resident's pain was addressed with rest period, repositioning, reassurance and distraction. The resident responded well to pain interventions and the assessment was completed. Wound documentation dated 12/31/25 by RN #254 revealed Resident #23 had a Stage II pressure ulcer to lower back that was deteriorating. The area measured 2.5 cm long and 1 cm wide with 100% slough. The TAR for January 2026 revealed Resident #23's upper mid back was to be cleansed with normal saline or a wound cleanser, patted dry, Medi honey, and calcium alginate to be applied, and covered with an abdominal (ABD) pad and a gauze wrap bandage every day for wound care. The treatment was documented as being completed three (01/05/26, 01/07/26, and 01/12/26) out of 14 days. There was no documentation of the treatment being completed as needed. The Braden Scale Observation assessment dated [DATE] revealed Resident #23 scored a 17 which indicated the resident was at risk for the development of pressure ulcers. Wound documentation dated 01/07/26 by NP #515, from an outside wound company, revealed Resident #23 was under hospice care (this is not accurate as the resident was not receiving hospice services). Resident #23 had an Unstageable pressure ulcer to upper spine that measured 3.5 cm long and 2.5 cm wide. There was 70% granulation and 30% slough with moderate serosanguinous exudate. The peri wound was ecchymotic and the wound had declined. The resident had declining medical condition, dementia/confusion, and poorly compliant with offloading that have contributed to the decline of the wound (there was no documentation of the resident being non-compliant with treatment including offloading, and the resident did not have a plan of care in place for non-compliance). An additional wound was evaluated and identified as Wound #3 that was present upon admission. The wound was a Stage III (involves full-thickness skin loss where fat tissue was visible, but bone, tendon, or muscle were not exposed) pressure ulcer to the upper spine. The Stage III pressure ulcer measured 1.5 cm long, 1 cm wide, and 0.1 cm deep. There was 90% granulation and 10% slough and a moderate amount of serosanguinous exudate. This was the initial evaluation of the Stage III pressure ulcer. Resident #23 had poor nutritional intake, dementia/confusion, incontinence, and overall poor medical condition making the presence of the wound unavoidable. A new order was given for the wound to be cleansed with normal saline, covered with calcium alginate and a bordered gauze dressing. The treatment was to be completed daily and as needed. Any medical grade honey may be used. The resident had mild transient pain during wound assessment. The resident's pain was addressed with rest period, repositioning, reassurance and distraction. The resident responded well to pain interventions and the assessment was completed. Wound documentation dated 01/07/26 by RN #254 revealed Resident #23 had an Unstageable pressure ulcer to lower back that was deteriorating. The area measured 16.33 cm long and 2 cm wide. The wound bed had 70% granulation and 30% slough. There was a moderate amount of serosanguineous exudate with an odor after cleansing. A nurse's note dated 01/13/26 at 1:34 P.M. revealed documentation noted to be incorrect, and the wound provider notified for clarification of wound information. The Braden Scale Observation assessment dated [DATE] revealed Resident #23 scored a 16 which indicated the resident was at risk for the development of pressure ulcers. Wound documentation dated (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	01/14/26 by NP #515, from an outside wound company, revealed Resident #23 had a surgical wound (no longer identified as an unstageable pressure ulcer) to lower spine with full-thickness depth exposure and the wound measured 4 cm long and 2 cm wide. The depth was not able to be determine and the wound bed was covered with 20% granulation and 80% slough. There was a moderate amount of serosanguinous exudate, and the wound bed was ecchymotic. The wound had declined. Debridement was completed using a scalpel and the wound was debrided down to the subcutaneous tissue. Post debridement measurements were 4.2 cm long and 2.6 cm wide and depth was not determined. The wound to the upper spine, identified as Wound #3, was now described as a surgical wound (no longer identified as a Stage III pressure ulcer) that was present upon admission. There was full-thickness depth exposure, and the wound measured 2.5 cm long, 2.0 cm wide, and 0.1 cm deep. The wound bed had 90% granulation and 10% slough with moderate serosanguinous exudate. The wound had declined and the wound was identified as unavoidable. The treatment was to continue as ordered. An observation on 01/12/26 at 11:09 A.M. revealed Resident #23 was lying in bed. The resident did not have an air mattress in place. An interview on 01/15/26 at 10:25 A.M., RN #254 verified she was the facility wound nurse. RN #254 stated that she used a camera to take pictures of the wounds. A sticker was placed on the resident, and the camera measured the wound and the location of the wound. The angle of the camera, the way the resident was lying, or shadows could change the measurements of the wound. RN #254 demonstrated the location of Resident #23's wound was approximately between the lower shoulder blades on the spine area. RN #254 stated the mid back and lower back wounds were the same wound just identified differently. RN #254 verified the TARs for December 2025, and January 2026 revealed the treatments were not completed as ordered. RN #254 also verified Resident #23 did not have an air mattress in place but stated one had been ordered and would be put in place when it arrived. An interview on 01/15/26 at 4:03 P.M. with NP #515 revealed the areas to Resident #23's back were just pinpoint areas when the resident was admitted . The facility wound nurse (RN #254) was assessing those areas. The areas to the resident's back were not improving, and he was asked to look at the areas, and the wounds did not look good. NP #515 stated he did not hear RN #254 tell him the wounds were surgical and was confused when RN #254 told him on 01/14/26 that the areas were surgical. NP #515 stated there was miscommunication and he was going by what RN #254 said. NP #515 verified an air mattress should be put in place for anyone that was fragile and at risk for developing pressure ulcers. NP #515 verified Resident #23 should have had an air mattress put in place. An additional interview on 01/20/26 at 8:15 A.M., RN #254 verified the care plan was not updated to address the pressure ulcer to Resident #23's back. RN #254 stated Resident #23 had surgery to his back, and the area was closed with skin adhesive. RN #254 verified the area to Resident #23's back was not identified until two days (12/08/25) after the resident was admitted and an order for treatment was not put in place until 12/10/25. RN #254 stated she first identified the area to the resident's back as a surgical wound. RN #254 stated there was miscommunication between herself and NP #515 and the wound was changed to a pressure ulcer but was now changed back to a surgical wound. RN #254 verified there were two areas to the resident's back, but the wounds had been treated as one area. RN #254 also verified the treatments to Resident #23's back were not completed daily as ordered. An interview on 01/21/26 at 7:32 A.M., the Director of Nursing verified the Braden Assessments were incorrect, and Resident #23 was at high risk for the development of pressure ulcers. An interview on 01/21/26 at 9:39 A.M., NP #515 stated the areas to Resident #23's back were from incisions and not pressure. NP #515 verified the areas were on the resident's spine (bony prominence) and were not from dehiscence (spontaneous splitting or gaping open from an incision). NP #515 stated the areas were present upon admission and the resident possibly had developed an abscess (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	due to copious amounts of drainage. NP #515 verified there was no documentation of copious amounts of drainage or possible abscesses. NP #515 verified the areas had gotten worse because the resident was very fragile. NP #515 stated the resident was noncompliant with repositioning because the resident yelled out when he was turned on his side. An interview on 01/21/26 at 9:45 A.M., RN #254 verified Resident #23 did not receive hospice services at this time but there had been a discussion with Resident #23's family about hospice services. RN #254 verified there was no documentation of Resident #23 being noncompliant with care. An observation on 01/21/26 at 9:50 A.M. of Resident #23's back revealed an area to the spine area above the waistline and an area to the upper back to the spine area between the shoulder blades. The wounds appeared to be approximately the size of a 50-cent piece and were covered with white/yellow slough. The skin around the wounds was reddened but blanchable. An interview on 01/21/26 at 10:56 A.M., Regional MDS #600 verified the 5-day MDS dated [DATE] identified the Stage II was to Resident #23's back and the skin tear was the wound to the resident's thigh. Regional MDS #600 verified no surgical wounds were identified during the assessment period. 2) Review of the medical record revealed Resident #8 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included neuropathy, sick sinus syndrome, dysphagia, congestive heart failure, urogenital implants, acute kidney failure, and anxiety disorder. Review of Resident #8's TAR revealed on 10/20/25, Resident #8 was to have a pressure reduction mattress every shift. The staff continued to sign the TAR through 01/14/26 verifying a pressure reduction mattress was in place. Review of the December (2025) and January (2026) TAR revealed no documentation of barrier cream being applied after each incontinence episode as needed. The plan of care dated 10/19/25 and revised on 11/01/25 revealed Resident #8 had the potential for skin breakdown/pressure ulcers. Interventions included administer treatments, assistance with turning and repositioning as indicated and tolerated, and skin to be checked during daily skin care. The 5-day MDS dated [DATE] revealed Resident #8 had severe cognitive impairment. The resident was dependent for mobility, bathing, and toileting. The resident required substantial/maximal assistance rolling left to right, sitting to lying, lying to sitting, and sitting to standing. Resident #8 had no skin concerns. Review of the resident's medical record revealed on 12/10/25, Resident #8 weighed 144 pounds. On 01/05/26, Resident #8 weighed 121 pounds. Facility skin issue documentation dated 01/13/26 revealed Resident #8 had a new skin issue. The resident had a Stage II pressure ulcer to the right gluteus that was in-house acquired. The wound measured 0.74 cm long and 0.35 cm wide. There was no exudate noted. The wound was to be cleansed with generic wound cleanser, zinc cream applied, and foam dressing applied. Additional care included incontinence management and mobility aid. An outside wound company note dated 01/14/26 revealed Resident #8 was being seen for an initial consultation for wound care. Resident #8 was seen today for a Stage II pressure ulcer to the right buttock. The pressure ulcer measured one cm long, 0.5 cm wide, and was 0.1 cm deep. There was light serous (clear, thin, watery, pale yellow body fluid) exudate. An order was received for the wound to be cleansed with normal saline and zinc oxide cream to be applied every shift. Facility skin issue documentation dated 01/14/26 revealed Resident #8 had a Stage II pressure ulcer to right gluteus that was in-house acquired. An observation on 01/12/26 at 3:00 P.M. revealed Resident #8 was lying in bed, and the air mattress setting was 170 pounds. An observation on 01/13/26 at 7:51 A.M. revealed Resident #8 was lying in bed, and the air mattress was 170 pounds. On 01/13/26 at 8:02 A.M. Registered Nurse (RN) #232 verified that the air mattress was set to 170 pounds. RN #232 verified he was not aware how much Resident #8 weighed and if the air mattress was at the correct setting. On 01/13/26 at 8:11 A.M. the facility wound nurse, RN #254, verified they were not aware how much Resident #8 weighed and what the setting on the air mattress should be set at. An interview on (continued on next page)

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	366418	A. Building B. Wing	01/26/2026

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F 0686 Level of Harm - Actual harm Residents Affected - Few	01/15/26 at 9:57 A.M. with the Administrator verified there were no orders for Resident #8 to have an air mattress and the Administrator was unable to say how long the air mattress had been in place. An interview on 01/15/26 at 4:03 P.M. NP #515 verified Resident #8 had a new area to the right gluteus/buttock. NP #515 stated an air mattress would provide greater benefits than a regular pressure relieving mattress. NP #515 stated there would not be much of an impact if the air mattress was at the wrong setting for a short period of time; however, a firmer setting for a long period of time, could result in possible pressure areas. An interview on 01/20/26 at 8:47 A.M. with RN #232 verified Resident #8's area to the right gluteus/buttock was not present upon admission but was discovered on 01/13/26 while the resident was being bathed. At the time of this interview, an observation was also made of the wound to Resident #8's gluteus/buttock and revealed the wound was healing. 3) Review of the medical record for Resident #61 revealed an admission date of 11/28/20. Diagnoses included multiple sclerosis, polyneuropathy in diseases classified elsewhere, anxiety disorder, major depressive disorder, insomnia, auditory hallucinations, other specified dorsopathies of the cervical region, chronic pain syndrome, generalized muscle weakness, other muscle spasm, gastroesophageal reflux disease without esophagitis, Vitamin D deficiency, pityriasis versicolor, unspecified exotropia, and weakness. Review of the Quarterly MDS dated [DATE] identified the resident was cognitively intact with a BIMS score of 15, had impairment of both lower extremities, used a wheelchair, was independent with eating and upper body hygiene, and dependent for lower extremity dressing, footwear, and transfers. The resident was at risk for skin breakdown due to generalized muscle weakness, immobility, and maximal dependence on staff for repositioning. Review of physician orders revealed an active skin prevention order for a low air loss mattress, with instructions to check function every shift. There was no order specifying the appropriate weight dial setting for the mattress. Review of progress notes and skin assessments revealed the resident had a history of moisture-associated skin damage (MASD) to the right gluteus, with ongoing care including turning and repositioning, moisture barrier, incontinence management, and nutrition supplementation. Review of care plans revealed no documentation of interventions to ensure the air mattress was set appropriately for the resident's weight to prevent further skin breakdown. Observation on 01/20/26 at 10:27 AM revealed the air mattress was set to 325 pounds, while the resident's documented weight was 172.9 pounds on 01/01/26 at 7:11 P.M. Licensed Practical Nurse (LPN) #224 confirmed at the time of the observation that the dial was too high for the resident's weight and stated the DON instructed staff to raise the dial to make the bed firm enough for the resident. Review of the Wound Care policy (dated October 2010) revealed documentation of the type of wound care given, the date and time of wound care given, the position in which the resident was placed, any change in the resident's condition, all assessment data (wound bed color, size, drainage, etc.) obtained when inspecting the wound, how the resident tolerated the procedure, and if the resident refused the treatment, should be recorded in the resident's medical record. The supervisor should be notified if the resident refused wound care. This deficiency represents non-compliance investigated under Complaint Numbers 1350537 and 2708970.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, and facility policy review the facility failed to provide a safe and homelike environment for residents including unsecured medications, fall prevention interventions, and functionality of facility doors. This affected five residents (#5, #10, #19, #31, #37) of five residents reviewed. The facility census was 65.Findings include: 1. Medical record review for Resident #31 revealed he was admitted to the facility on [DATE]. His diagnoses included obstructive sleep apnea, asthma, depression, allergic rhinitis, diabetes mellitus (DM), hypothyroidism, peripheral vascular disease, anxiety disorder, and venous insufficiency. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 was cognitively intact. Resident #31 was dependent on staff for medication administration. Resident #31 required set up assistance from staff with eating, oral hygiene, toilet use, lower body dressing, putting on shoes, and personal hygiene. He required supervision with showers. Review of the physician Order Summary for Resident #31 revealed an order for the following medications; for Promethazine (for nausea and vomiting) 25 milligram (mg) dated 01/07/26 as needed with self-administration with nurse supervision, alzelastine (allergies) .1% dated 07/16/24 two sprays daily, dulera (asthma) inhaler dated 09/20/24 two puffs inhaled daily, Albuterol inhaler aerosol inhalation (shortness of breath)108 dated 11/20/24 two puffs every six hours as needed, Fluticasone propionate suspension (allergies) 50 mcg (microgram) dated 07/16/24,dulera (asthma) inhalation aerosol 100-5 mcg/act two puffs dated 09/20/24, Albuterol sulfate (shortness of breath) dated 11/20/24 two puffs every six hours as needed, betamethasone Dipropionate cream (for scars) .1% apply to left and right knee daily dated 04/03/24, clotrimazole-betamethasone external cream (foot fungal infection) 1-0.05% dated 07/18/24 apply to feet two times daily, and ammonium lactate 12% (affected skin areas) dated 11/12/24 apply to affected skin once daily Observation on 01/12/26 at 9:49 A.M. revealed Resident #31 was in his room. Identified the following medications in his room. Observed some of the medications were lying at the foot of his bed in a clear plastic return from the hospital bag and others were stuffed in his backpack. Observed Promethazine on the bedside table, and the following additional medications in Resident #31's room , alzelastine (allergies) .1% , dulera (asthma) inhaler, Albuterol inhaler aerosol inhalation (shortness of breath), dulera (asthma) inhalation aerosol, Albuterol sulfate (shortness of breath), betamethasone Dipropionate cream (for scars), clotrimazole-betamethasone external cream (foot fungal infection, and ammonium lactate 12% (affected skin areas), Symbicort (shortness of breath), and Breo Ellipta (asthma). Interview on 01/12/26 at 9:49 A.M. with Resident #31 confirmed he keeps medication in his room. Resident #31 pointed at the medication on his bedside table (Promethazine) and stated he is allowed to take that when he needs it. Resident #31 confirmed he had other medications in his room and some of the medications he did not have orders for. Resident #31 pulled bags of medication from his hospital stay bags lying in his room. Resident #31 stated he keeps medications in his room as evidence that the facility is not following doctor's orders. Interview on 01/12/26 at 10:29 A.M. with Registered Nurse (RN) #287 confirmed the following medications were found in Resident #31's room; observed Promethazine on the bedside table, and the following additional medications in Resident #31's room , alzelastine (allergies) .1% , dulera (asthma) (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	inhaler, Albuterol inhaler aerosol inhalation (shortness of breath), dulera (asthma) inhalation aerosol, Albuterol sulfate (shortness of breath), betamethasone Dipropionate cream (for scars), clotrimazole-betamethasone external cream (foot fungal infection, and ammonium lactate 12% (affected skin areas), Symbicort (shortness of breath), and Breo Ellipta (asthma). RN #287 confirmed Resident #31 did not have an active order for the Breo Ellipta (asthma) medication or Symbicort (shortness of breath) medications. Interview on 01/12/26 at 4:25 P.M. with the Administrator confirmed she was aware that Resident #31 kept a medication in his room and that is because he has am assessment and order to self-administer medication. The Administrator confirmed there is only one medication that had an order to self-administer under the supervision of a nurse and that was the medication Promethazine. She confirmed Resident #31 did not have an order to self-administer any other medications. 2. Medical record review for Resident #37 revealed he was admitted to the facility on [DATE]. His diagnoses included cardiomegaly, mixed hyperlipidemia, primary osteoarthritis, sleep apnea, primary osteoarthritis, obstructive sleep apnea, obesity, congestive heart failure, and hypertension. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #37 was cognitively intact. Resident #37 was dependent on staff for medication administration; Resident #37 was independent with eating and personal hygiene. He required moderate assistance from staff with putting on shoes. He required maximum assistance from staff with toilet use, bathing, upper body dressing, lower body dressing, Review of the physician orders for Resident #37 confirmed the following medications were ordered; Spironolactone (hypotension) 25mg dated 03/10/25, Senna -s (constipation) 8.6-50 mg dated 04/03/25, amiodarone (abnormal heart rhythm) 200 mg dated 03/10/25, empagliflozin (diabetes mellitus) 10 mg, dated 03/11/25, Losartan (high blood pressure) 25mg start dated 03/11/25, Metoprolol Succinate (high blood pressure) 50 mg dated 03/10/25, potassium chloride ER 20 milliequivalent (mcg) (diuretic therapy) dated 10/14/25. Observation on 01/12/26 at 10:30 A.M. revealed Resident #37 had a cup of medications on his bedside table. The cup contained a total of six pills. Interview on 01/12/26 at 10:31 A.M. with Registered Nurse (RN) #287 confirmed Resident #37 had the following medications in a medicine cup on his bedside table. RN #287 confirmed it was the morning medication for Resident #37. She confirmed the following medications were in the cup located on the bedside table; potassium chloride 20 MEQ, Senna 8.6-5-mg, amiodarone 200 mg, empagliflozin 10 mg, lozartin 25 mg, Metoprolol 50 mg, and Spironolactone 25 mg. RN #287 confirmed Resident #37 is unable to self-administer medications. Review of the facility policy titled, Medication Administration, undated, confirmed all medications are administered safely and appropriately aide residents to overcome illness. Further review of the policy confirmed medications are administered only by licensed nursing personnel or a physician. Review of the facility policy titled, Medication Labeling and Storage, dated February 2023, confirmed the facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls. Only authorized personnel have access to keys. Review of the facility policy titled, Homelike Environment, dated February 2021, confirmed (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents are provided with a safe homelike environment. 3. Record review for Resident #10 revealed she was admitted to the facility on [DATE]. Her diagnoses included spinal stenosis, diabetes mellitus, bipolar disorder, anxiety disorder, attention-deficit disorder, depressive disorder, gastro-esophageal reflux disorder (GERD), major depressive disorder, primary osteoarthritis, and insomnia. Review of the Minimum Data Set (MDS) assessment for Resident #10 dated 10/29/25 revealed Resident #10 was cognitively intact. Further review for Resident #10 revealed she was dependent on staff for medication administration. She required supervision from staff with eating, toilet use, bathing, Resident #10 was independent with oral hygiene, upper body dressing, lower body dressing, putting on shoes, and personal hygiene. Review of the progress notes for Resident #10 revealed a late entry fall note was written on 10/14/25 at 8:40 A.M. for 10/09/25 at 11:46. This note confirmed Resident #10 had a fall from her bed and sustained a skin tear to the right forehead that measured 2 centimeters (cm) by .75 cm. the wound was cleansed and applied dry dressing. Review of the fall care plan for Resident #10 dated 10/10/25 revealed to assure Resident #10 to utilize 1/2 handrail to the right side of the bed. Interview on 01/15/26 at 3:05 P.M. with the DON confirmed the facility failed to identify Resident #10's fall on 10/09/25 until a late entry fall note was written on 10/14/25 at 8:40 A.M. The late entry note revealed Resident #10 had a fall on 10/09/25 at 11:46 P.M. Resident #10 stated she was reaching for something on her bedside table and ended up on the floor. Resident #10 sustained a skin tear to the right forehead. Further review of the notes confirmed the facility initiated the fall intervention to utilize arm rails until 10/14/25. 4. Review of Resident #19's medical record revealed he was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, diabetes, anxiety, depression, absence of the right great toe and peripheral vascular disease. Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed his cognition was intact. He requires supervision or touching assistance for eating, oral hygiene, toileting, shower/bathing, dressing, personal hygiene and independent for turning and repositioning. Occasionally incontinent of urine and always continent of bowel. Review of the progress notes dated 12/31/25 at 10:20 A.M. revealed a skin issue to the left big toe and a treatment was started. On 01/14/26 at 7:40 A.M. interview with Resident #19 revealed the wound to his toe happened when the front door was broken and it had slammed on his toe. On 01/15/26 at 11:07 A.M. interview with Registered Nurse (RN) #246 revealed she received communication from the facility nurse revealed Resident #19 had gotten his toe crushed in the front door on 01/03/26 (door was broken at that time). She also verified it was not documented on the incident accident log and no documentation in the medical record. On 01/15/26 at 1:27 P.M. interview with the Maintenance Director revealed the front door was fixed by an outside vendor on 01/06/26. It was first reported broken on 12/14/25. The reason it took so long was because they had to order parts. 5. Review of the medical record for Resident #5 revealed an admission date of 09/01/23. Diagnoses (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366418	A. Building B. Wing	01/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, psychomotor deficit following cerebral infarction, respiratory failure, hypertensive heart disease with heart failure, chronic diastolic congestive heart failure, centrilobular emphysema, severe dementia, dysphagia, depression, mood disorder, convulsions, obesity, and atherosclerotic heart disease. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had severely impaired cognition, with a BIMS score of 2. The MDS further indicated the resident required extensive to total assistance for bed mobility and transfers, was dependent for toileting hygiene and lower extremity dressing, required maximum assistance with upper extremity dressing and rolling left and right, and utilized a wheelchair for mobility. Section J documented one fall since the last assessment with no injury. Review of the fall risk assessment dated [DATE] revealed the resident was assessed as a high fall risk, with a score of 18. Review of the plan of care revealed the resident was identified as being at risk for falls due to impaired mobility, cognitive impairment, and a history of falls. Fall-related interventions included: Assure 1/2 side rails bilaterally to assist with turning and repositioning and encourage appropriate use, initiated on 09/02/25 and revised on 10/20/25. Placement of fall mats to bilateral sides of the bed, initiated on 08/31/25 and revised on 11/05/25. Adjust air mattress to the resident's comfort to enable sitting on the side of the bed with needed support, initiated and revised on 10/20/25. Anticipate resident needs including hunger, thirst, toileting needs, comfort level, turning/repositioning, minimizing noise, and pain management, initiated on 07/15/25 and revised on 10/20/25. Encourage use of wheelchair to go to the bathroom, initiated on 10/05/23 and revised on 07/15/25. Encourage use of proper, well-maintained non-skid footwear as tolerated, initiated and revised on 11/03/25. Ensure call light is within reach and encourage use for assistance as needed, initiated on 07/15/25. Offer toileting after all meals and provide check and change as needed, initiated on 01/22/24 and revised on 11/03/25. Reposition the resident to the center of the bed as needed to enhance safety and minimize fall risk, initiated on 09/02/25. Evaluate effectiveness of psychotropic medications with the physician for possible dose decrease or discontinuation, initiated on 09/04/23 and revised on 01/09/25. Observe for adverse medication effects including dizziness, drowsiness, and sedation and assist with ADLs and notify the physician or nurse practitioner if symptoms are observed, initiated on 09/04/23. Review of physician orders identified fall-related safety devices and interventions consistent with the care plan, including use of fall mats and bed rails for assistance with maneuverability. Review of the bed rail assessment dated [DATE] revealed the 1/2 bed rails were to assist with maneuverability. Review of nursing notes dated 08/31/25 at approximately 6:45 PM revealed the resident was found partially on the floor, lying on his back with his head against the bed and his right arm and hand stuck between the bed rail and frame. The fall was unwitnessed. The resident was confused and unable to state why he was on the floor. The resident complained of right shoulder, arm, and hand pain, with bruising noted. Three staff assisted the resident back to bed using a mechanical lift. Review of nursing notes dated 11/01/25 at approximately 2:30 PM revealed the resident was found on his knees on the floor mat next to the bed, holding the bed rail with his left hand. The fall was (continued on next page)

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	366418	A. Building B. Wing	01/26/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unwitnessed. The resident stated he wanted to go to the restroom. A skin tear to the right wrist was noted. The resident complained of knee pain and received PRN pain medication. The post-fall documentation indicated all safety interventions were in place at the time of the occurrence. Review of the post-fall assessment dated [DATE] indicated the resident remained alert and oriented with confusion, consistent with baseline, and neuro checks were initiated. An intervention to offer toileting after meals and provide check and change as needed was documented. Observation on 01/12/26 at 10:03 AM revealed the resident's bed was raised and a fall mat was present on both sides of the bed; however, the fall mat on the left side was pushed almost completely underneath the bed, limiting its ability to provide protection in the event of a fall. Interview on 01/12/26 at approximately 10:28 AM with Registered Nurse (RN) #200 confirmed the resident's bed was not in the lowest position and the fall mat on the left side was positioned too far under the bed. RN #200 stated that if the resident were to fall from the bed, he would fall directly onto the floor. RN #200 repositioned the fall mat at the time of the interview. RN #200 stated there was no specific physician order for the bed to be maintained in the lowest position, but that it was facility protocol to keep beds in the lowest position for resident safety. Review of the facility policy titled Falls and Fall Risk, Managing (revised March 2018) revealed that staff implement resident-centered fall prevention interventions based on specific risk factors and causes. Interventions are introduced gradually (one or a few at a time) and may include exercise/balance training, better footwear, room rearrangement, improved lighting, medication review/adjustment with physician and pharmacist input, hip padding or osteoporosis treatment, and addressing environmental hazards like wet floors, poor lighting, obstacles, improper bed height, or unsafe wheelchairs. Position-change alarms support monitoring but are not primary or sole interventions, with prompt staff response required. If falls continue, staff add or change interventions until falls decrease or unavoidable causes are documented. Ongoing monitoring tracks response, with re-evaluation and physician input for persistent issues, and notation of irreversible risks. This deficiency represents non-compliance investigated under Complaint Number 2669834, 1350536.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366418	A. Building B. Wing	01/26/2026

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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 record review, interview, and policy review, the facility failed to ensure the bowel protocol was followed for Resident #3. This affected one resident (#3) of three residents reviewed for bowel and bladder incontinence. The facility census was 65.Findings include:Review of the medical record revealed Resident #3 was admitted on [DATE] with diagnoses that included necrotizing fasciitis, acute and chronic respiratory failure, type 2 diabetes, and obstructive and reflux uropathy. The admission Minimum Data Set (MDS) dated [DATE] revealed Resident #3 was cognitively intact. The resident had an indwelling catheter and was always incontinent of bowel. Plan of care dated 11/13/25 revealed Resident #3 had bowel incontinence. Interventions included to check and change the resident and encourage the resident to use the call light for toileting assistance. An additional plan of care dated 11/13/25 revealed Resident #3 had an activity of daily living self-care performance deficit. Interventions included that the resident was totally dependent on one staff member for toileting. Review of the bowel movement documentation revealed Resident #3 did not have a bowel movement on 12/23/25, 12/24/25, 12/25/25, and 12/26/25. An interview on 01/14/26 at 2:31 P.M. Director of Nursing (DON) verified Resident #3 did not have a bowel movement for four days and there was no bowel interventions put in place. The DON verified the Bowel Management Protocol should have been followed. The Bowel Management Protocol policy dated 02/15/15 revealed it was the policy of the facility to ensure that residents were free from complications secondary to constipation. This will be accomplished through adequate assessment, tracking and treatment as indicated. The normal bowel pattern was once every day up to once every three days. Constipation results from factors such as immobility, decreased activity, and as a side effect of numerous medications. The nurse will provide medication as ordered by the physician or obtain a physician's order, to residents on the bowel care list. The medication given should be recorded on the MAR and bowel care list. The nurse is to follow up on those residents on the bowel care list for results. This deficiency represents non-compliance investigated under Complaint Number 2708970.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366418	A. Building B. Wing	01/26/2026

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy review the facility failed to ensure weight loss was adequately addressed for Resident #8 and proper follow up was completed after Resident #6 had significant weight loss. This affected two residents (#6, #8) of eight residents reviewed for nutrition. The facility census was 65.Findings include: 1.Review of the medical record revealed Resident #8 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included neuropathy, sick sinus syndrome, dysphagia, congestive heart failure, urogenital implants, acute kidney failure, and anxiety disorder. Review of the plan of care for nutrition dated 10/22/25 revealed Resident #8 had the potential for altered nutrition related to past medical history of left femur fracture, anemia, anxiety, with varied intakes related to vomiting, recent surgery, and significant weight loss updated on 01/06/26. Interventions included house supplements as ordered, offer snacks as indicated, and diet, supplements, and vitamins/minerals per physician order Review of the 5-day Minimum Data Set (MDS) dated [DATE] revealed Resident #8 had severe cognitive impairment. The resident required set up or clean-up assistance for eating. During the assessment time period the MDS revealed the resident had no concerns with weight loss and weighed 144 pounds. A weight change note dated 01/06/26 at 3:08 P.M. revealed Resident #8 weighed 121 pounds on 01/05/26. This indicated a significant weight loss of 15.7% in the last 30 days and 10% in the last 90 days. Resident #8 received a regular diet, regular texture, and thin liquids. The resident ate 51-100% of most meals. Resident #8 had a fluid restriction of 1500 milliliters a day. Resident #8 was ordered a Boost Breeze eight ounce supplement every day and the supplement was accepted well per the medication administration record (MAR). Recommendations were made to add a frozen nutritional treat supplement twice a day and for weekly weights to be completed. Nursing was updated about Resident #8's weight loss. On 01/06/26 at 3:17 P.M. Resident #8 was ordered frozen nutritional treats twice a day with lunch and dinner. Review of the MAR revealed the frozen nutritional treats were started on 01/07/26 and Resident #8 ate 100% of the frozen nutritional treats twice a day through lunch on 01/14/26. An observation on 01/14/26 at 11:46 A.M. revealed a frozen nutritional treat was not on Resident #8's lunch tray. An interview on 01/14/26 at 11:49 A.M. with Certified Nursing Assistant (CNA) #344 revealed Resident #8's meal ticket did not reveal a frozen nutritional treat was to be served with lunch. CNA #344 verified a frozen nutritional treat would be put on the tray by dietary staff and the frozen nutritional treat was not on Resident #8's lunch tray. An observation of the meal ticket revealed Resident #8 ate in her room, was on a regular diet, with regular texture, and thin liquids. At the bottom of the lunch ticket, it revealed Resident #8 was to receive half portions and milk. Review of the MAR on 01/14/26 at 12:05 P.M. revealed Resident #8 consumed 100% of the frozen nutritional treat. (continued on next page)

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	366418	A. Building B. Wing	01/26/2026

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 01/14/26 at 12:09 P.M. Registered Nurse (RN) #237 verified she documented Resident #8 ate 100% of the frozen nutritional treat. RN #237 asked CNA #344 if there had been a frozen nutritional treat on Resident #8's lunch tray. CNA #344 verified a frozen nutritional treat was not on the resident's lunch tray. RN #237 verified she documented Resident #8 ate 100% of the supplement without verifying the supplement had been served or consumed. An interview on 01/14/26 at 12:17 P.M. Dietary Director #216 verified an order had been placed on 01/07/26 for Resident #8 to have a frozen nutritional treat with lunch and supper. Dietary Director #216 verified the order was placed in the electronic record, but dietary staff had not been notified that Resident #8 was to receive the frozen nutritional treat with lunch and supper; therefore Resident #8's meal ticket had not been updated. Dietary Director #216 stated the dietary staff would not know to put a frozen nutritional treat on Resident #8's lunch and supper tray. Dietary Director #216 verified frozen nutritional treats had not been sent to Resident #8 during the month of January. Dietary Director #216 stated half portions were provided to Resident #8 per the resident's request. An interview on 01/21/26 at 8:30 A.M. Dietician #500 verified she was not aware Resident #8 had requested half portions. Dietician #500 also verified she used the documentation in the medical record to see if residents were consuming the supplements as ordered. Dietician #500 stated inaccurate documentation of residents consuming 100% of supplements could affect additional interventions that would need to be put in place if the resident continued to lose weight. Dietician #500 verified she had recommended weekly weights be done for Resident #8. An interview on 01/21/26 at 8:49 A.M. Director of Nursing (DON) verified weekly weights were not being completed for Resident #8. The DON verified Resident #8 should have been weighed on 01/12/26 and 01/19/26. The Weight Assessment and Intervention policy dated September 2008 revealed any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the Dietitian in writing. The Dietitian will respond within 24 hours of receipt of written notification. Assessment information shall be analyzed by the multidisciplinary team and conclusion shall be made regarding the approximate calorie, protein, and other nutrient needs compared with the resident's current intake. Interventions for undesirable weight loss shall be based on careful consideration of the resident's choice and preferences, nutrition and hydration needs of the resident, and the sued of supplements. 2. Review of the medical record for Resident #6 revealed an admission date of 06/23/22, with a re-entry date of 06/12/24. Diagnoses included, but were not limited to, neurocognitive disorder with Lewy bodies, unspecified dementia with behavioral disturbance, dementia with mood disturbance, cognitive communication deficit, bipolar disorder, major depressive disorder, anxiety disorder, insomnia, anorexia, hypotension, venous insufficiency, peripheral vascular disease, edema, hyperlipidemia, syncope and collapse, and acute embolism and thrombosis of an unspecified vein. Review of the admission nursing assessment revealed the resident's admission weight was documented as 149 pounds. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severely impaired cognition, with a BIMS score of 1, and required maximum assistance for eating. Section K of the MDS indicated no weight loss in the last six months. (continued on next page)

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	366418	A. Building B. Wing	01/26/2026

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a subsequent Quarterly MDS dated [DATE] again revealed a BIMS score of one, continued need for maximum assistance with eating, and again indicated no weight loss, despite documented weight declines during the same time frame. Review of the nutrition risk assessment dated [DATE] revealed the resident was identified as at risk for nutritional compromise related to dementia, anorexia, and a history of weight fluctuations. The assessment documented a 10.7% weight loss over the prior 90 days and established a goal to maintain stable weight. The resident was documented to be on a regular diet with regular texture and thin liquids, with Boost nutritional supplementation in place. Review of the plan of care dated 06/13/2025 revealed the resident was at risk for weight loss due to dementia, anorexia, and poor oral intake. Interventions included: Weekly weights Administration of Boost 8 fl oz daily Total assistance with all meals Offering alternative foods if <50% of meal consumed Notification of nurse manager if resident refused meals or supplements Review of physician orders for June 2025–January 2026 identified orders for weekly weights, Boost supplementation, and full assistance with meals. No new orders were initiated in response to the significant weight losses. Review of the nurses' notes revealed: On 07/26/25, the resident weighed 164.2 lbs; by 08/01/2025, the resident weighed 146.6 lbs, a 10.7% loss in six days. No documentation was found indicating notification of the dietitian or physician. On 11/21/25, the resident weighed 161.2 lbs; by 11/24/25, the resident weighed 152 lbs, a 5.71% loss in three days. Again, no documentation indicated notification of the dietitian or physician. On 01/09/26, the resident weighed 145 lbs, representing a 10.05% loss since 11/21/25. Review of the dietary progress notes revealed multiple weight warning notes (e.g., 08/11/25, 09/05/25, 10/08/25, 11/05/25, 12/03/25, 12/05/25, 12/06/25, 01/06/26). These notes documented fluctuations and acknowledged weight loss but did not indicate any follow-up interventions or timely notifications to the dietitian or physician after the 07/26/25–08/01/25 or 11/21/25–11/24/25 losses. Review of weights confirmed: 07/26/2025 – 164.2 lbs 08/01/2025 – 146.6 lbs (-10.7%) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366418	A. Building B. Wing	01/26/2026

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/21/2025 – 161.2 lbs 11/24/2025 – 152 lbs (-5.71%) 01/09/2026 – 145 lbs (-10.05%) Interview with Dietician #500, on 01/14/26 at 1:06 PM revealed the dietitian was not notified by staff of the significant weight loss from 07/26/25–08/01/25. She identified the weight loss herself on 08/04/25 and requested a re-weigh order on 08/06/25. The dietitian stated that the resident's weights fluctuate and Boost supplementation is adjusted based on weights, but that staff are supposed to notify her of any weight change ≥5 lbs, which did not occur during the July/August or November weight losses. Review of the facility policy titled Weight Monitoring and Nutritional Intervention, dated 06/13/2025, requires re-weighing the resident the next day for ≥5% weight change and notifying the dietitian. This policy was not followed during the significant weight loss events. This deficiency represents non-compliance investigated under Complaint Numbers 2669834, 2590724.

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	366418	A. Building B. Wing	01/26/2026

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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, record review, interview, policy review, and manufacture instructions revealed the facility failed to prime an insulin pen for Resident #56, the facility also failed to correctly read the number of insulin units for Resident #41 and failed to administer pantoprazole granules appropriately for Resident #84. This affected three (Resident #56, #41, and #84) out of two residents with insulin pens on the first floor and four residents on the first floor that received insulin via an insulin syringe, and two residents on the first floor that received pantoprazole granules. The surveyor observed 25 opportunities for error with three actual errors resulting in a medication error rate of 12%. The facility census was 65. Findings include: 1.Review of the medical record revealed Resident #84 was admitted on [DATE] with diagnoses that included chronic kidney disease and aftercare for joint replacement.Review of physician orders revealed Resident #84 was ordered pantoprazole (proton pump inhibitor to reduce stomach acid) 40 milligram (mg) packet. The packet was to be dissolved into five milliliters of apple juice and given once a day. An observation on 01/14/26 at 7:42 A.M. Certified Medication Aide (CMA) #333 poured pantoprazole packet into a cup of water and administered the pantoprazole to Resident #84.An interview on 01/14/26 at 10:44 A.M. Executive Director verified Resident #84's electronic medication administration record did not reveal pantoprazole granules to be administered in apple juice or apple sauce.Review of the website www.fda.gov revealed pantoprazole delayed-release oral suspension should be administered 30 minutes prior to a meal via oral administration in apple juice or applesauce. The proper pH is necessary for stability, do not administer pantoprazole in liquids other than apple juice, or foods other than applesauce. Pantoprazole oral administration in applesauce revealed the granules should be sprinkled on one teaspoonful of applesauce. DO NOT USE OTHER FOODS. Pantoprazole oral administration in apple juice revealed the granules should be mixed with one teaspoon of apple juice and stirred for five seconds. To make sure the entire dose is taken, rinse the container once or twice with apple juice to remove any remaining granules. Review of the Medication Labeling and Storage policy dated February 2023 revealed the medication label includes the appropriate instructions and precautions. Review of the Administration of Medication policy (no date) revealed it was the responsibility of the nursing profession to be aware of the classification, action, correct dosage, and side effects of a medication before administration. Procedures included to the check the medication administration record, read each order entirely, AND IF THERE WAS ANY DISCREPANCY BETWEEN THE MAR AND THE LABEL, CHECK THE PHYSICIAN ORDERS BEFORE ADMINISTERING. Review of the job description for Medication Aide (no date) revealed the administration of medications shall be in accordance with established nursing standards, the policies, procedures, and practices of the facility and the requirements of the state. Duties included to accurately and safely prepare, administer, and document the medications that were commonly used in the facility and may be ordered for resident use by the attending physician of the medical director. 2. Review of the medical record revealed Resident #41 was admitted [DATE] and readmitted on [DATE] with diagnoses that included metabolic encephalopathy and type 2 diabetes.A plan of care dated 10/21/25 revealed Resident #41 had the potential for unmanaged blood sugar levels and complications. Interventions included to administer medication as ordered and interventions to manage hypo/hyperglycemic episodes. The admission Minimum Data Set (MDS) dated [DATE] revealed Resident #41 was cognitively intact and received insulin injections. Review of physician orders revealed Resident #41 was ordered Lantus (insulin) 18 units twice a day. An observation on 01/14/26 at 7:57 A.M. revealed Registered Nurse (RN) #237 drew up Lantus in an insulin syringe. The surveyor asked to verify that 18 units were drawn up as ordered. The black stopper of the plunger was at 20 units. RN #237 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366418	A. Building B. Wing	01/26/2026

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated the surveyor was looking at the wrong side. RN #237 stated the lines on the left side of the syringe were one unit per line and the ones on the right side of the syringe were two units per line. RN #237 stated she had pulled up the 18 units as ordered. When questioned further by the surveyor, RN #237 looked at the syringe on the right side and did push the plunger up to the 18-unit mark. An interview on 01/14/26 at 9:36 A.M. Director of Nursing verified the insulin syringe was marked at one-unit increments on both sides of the syringe. 3. Review of the medical record revealed Resident #56 was admitted on [DATE] with diagnoses that included fracture of the left femur and type 2 diabetes. A plan of care dated 11/10/25 revealed Resident #56 had an altered endocrine system. Interventions included to monitor/document/report to the doctor signs and symptoms of hyperglycemia and hypoglycemia. The 5-day MDS dated [DATE] revealed Resident #56 had severely impaired cognition and received hypoglycemic injections.Review of physician orders revealed Resident #56 was ordered Humalog (insulin) 19 units before every meal.An observation on 01/14/26 at 7:34 A.M. CMA #333 removed a Humalog Kwik Pen from the medication cart. CMA #333 turned the dial to 19 units. CMA #333 stated the Kwik Pen was new and had not been used previously. The surveyor asked CMA #333 if the Kwik Pen needed to be primed. CMA #333 stated she did not understand. CMA #333 was again asked if the Kwik Pen needed to be primed before dialing up the ordered dose. CMA #333 stated she did not understand what priming was and entered Resident #56's room to administer the Humalog. Review of the instruction for use Humalog Kwik Pen revised on July 2023 revealed the instructions for use should be read each time you get a KwikPen. Priming the pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. To prime the pen, turn the dose knob to select two units, hold the pen with needle pointing up, tap the cartridge holder gently to collect air bubbles at the top, continue holding the pen with needle pointing up, push the dose knob until it stops and zero is seen in the dose window. Hold the dose knob in and count to five slowly. You should see insulin at the tip of the needle. After priming the pen, turn the dose knob to select the number of units you need to inject. Review of the job description for Medication Aide (no date) revealed the administration of medications shall be in accordance with established nursing standards, the policies, procedures, and practices of the facility and the requirements of the state. Duties included to accurately and safely prepare, administer, and document the medications that were commonly used in the facility and may be ordered for resident use by the attending physician of the medical director. This deficiency represents non-compliance investigated under Complaint Number 2594008.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366418	A. Building B. Wing	01/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dublin Post Acute	4075 West Dublin-Granville Road Dublin, OH 43017

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, resident interview, and staff interview, the facility failed to ensure residents were served food that was palatable and at an appropriate temperature. This had the potential to affect all 65 residents who receive food from the kitchen. The facility census was 65.Findings include:Observation on 01/14/26 at 12:08 P.M. after all resident room trays had been delivered, the test tray temperatures were obtained by the Dietary Manager (DM) #216. The beef macaroni casserole had a temperature of 131 Fahrenheit (F) and the mixed capri vegetables had a temperature of 120F.Review of the test tray on 01/14/26 at 12:10 P.M. with the Dietary Manager (DM) #216 revealed the beef macaroni casserole was lukewarm. DM #216 confirmed the beef macaroni casseroled should have had a much higher temperature reading. DM #216 stated he was surprised the vegetables did not taste even colder, related to the low temperature reading. DM #216 thought the improper temperatures of the test tray were related to how long the food cart sat on the unit prior to being served.Interview on 01/12/26 at 11:13 A.M. with Resident #34 revealed he thought the food was served cold.Interview on 01/12/26 at 11:40 AM with Resident #01 revealed he disliked the food at the facility. Resident #01 stated he did not like what is served or how it is cooked. He stated the food is served cold.Interview on 01/12/26 at 12:49 P.M. with Resident #10 revealed she thought the food that was served at the facility tasted terrible. Resident #10 stated the food was always served cold.Interview on 01/13/26 at 9:12 A.M. with Resident #37 revealed she felt the food at the facility was served cold with improper serving sizes.This deficiency represents non-compliance investigated under Complaint Number 2590724.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366418	A. Building B. Wing	01/26/2026

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, and interview the facility failed to ensure complete and accurate medical records. This affected two residents (#8, #48) of 24 residents reviewed for accuracy of medical records. The facility census was 65. Findings include: 1.Review of the medical record revealed Resident #8 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included neuropathy, sick sinus syndrome, dysphagia, congestive heart failure, urogenital implants, acute kidney failure, and anxiety disorder. Plan of care for nutrition dated 10/22/25 revealed Resident #8 had the potential for altered nutrition related to past medical history of left femur fracture, anemia, anxiety, with varied intakes related to vomiting, recent surgery, and significant weight loss updated 01/06/26. Interventions included house supplements as ordered, offer snacks as indicated, and diet, supplements, and vitamins/minerals per physician order. The 5-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 had severe cognitive impairment. The resident required set up or clean-up assistance for eating. During the assessment time period the MDS revealed the resident had no concerns with weight loss and weighed 144 pounds. A weight change note dated 01/06/26 at 3:08 P.M. revealed Resident #8 weighed 121 pounds on 01/05/26. This indicated a significant weight loss of 15.7% in the last 30 days and 10% in the last 90 days. A recommendation was made to add frozen nutritional treat supplement twice a day and weekly weights. On 01/06/26 at 3:17 P.M. Resident #8 was ordered frozen nutritional treats twice a day with lunch and dinner. Review of the Medication Administration Record (MAR) revealed the frozen nutritional treats were started on 01/07/26 and Resident #8 ate 100% of the frozen nutritional treats twice a day through lunch on 01/14/26. An observation 01/14/26 at 11:46 A.M. revealed a frozen nutritional treat was not on Resident #8's lunch tray. An interview on 01/14/26 at 11:49 A.M. with Certified Nursing Assistant (CNA) #344 revealed Resident #8's meal ticket did not reveal a frozen nutritional treat was to be served with lunch. CNA #344 verified a frozen nutritional treat would be put on the tray by dietary staff and the frozen nutritional treat was not on Resident #8's lunch tray. An observation of the meal ticket revealed Resident #8 ate in her room, was on a regular diet, with regular texture, and thin liquids. At the bottom of the lunch ticket it revealed Resident #8 was to receive half portions and milk. Review of the medication administration record (MAR) on 01/14/26 at 12:05 P.M. revealed Resident #8 consumed 100% of the frozen nutritional treat. An interview on 01/14/26 at 12:09 P.M. Registered Nurse (RN) #237 verified she documented Resident #8 ate 100% of the frozen nutritional treat. RN #237 asked certified nurse aide (CNA) #344 if there (continued on next page)

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	366418	A. Building B. Wing	01/26/2026

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had been a frozen nutritional treat on Resident #8's lunch tray. CNA #344 verified a frozen nutritional treat was not on the resident's lunch tray. An interview on 01/14/26 at 12:17 P.M. Dietary Director #216 verified frozen nutritional treats had not been sent to Resident #8 during the month of January (2026). 2. Review of the medical record for Resident #48 revealed an admission date of 08/14/2021 with a re-entry on 05/22/2025. Diagnoses included multiple sclerosis, refractory anemia, centrilobular emphysema, and mild persistent asthma. Review of the anticipated discharge Minimum Data Set (MDS) dated [DATE] indicated the resident was cognitively intact (BIMS 15) but totally dependent on staff for eating, oral hygiene, toileting, showering, upper and lower extremity dressing, personal hygiene, and transfers. The resident had an indwelling catheter, was occasionally incontinent of urine, and always incontinent of bowel. Review of the medical record revealed a positive urine dipstick for leukocytes and/or nitrate on 11/12/25, and orders were placed for urine cultures on 11/13/2025 and 11/18/2025. Both cultures returned contaminated, with greater than three organisms isolated, and lab instructions indicated follow-up if clinically indicated. There was no documentation in the medical record of any follow-up, evaluation, or intervention related to these positive results or the resident's reported abdominal pain. No laboratory results for the positive dipstick were included in the chart. Interview on 01/15/26 at 2:17 PM with Licensed Practical Nurse (LPN) #318 confirmed that after the positive dipstick, the urine cultures on 11/13/25 and 11/18/25 were contaminated and no follow-up was completed to determine if the resident had a UTI. She stated that there was no documentation in the medical record addressing the positive dipstick results, the contaminated cultures, or any evaluation for infection. This deficiency represents non-compliance investigated under Complaint Number 2669834.