

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366418	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/04/2026
NAME OF PROVIDER OR SUPPLIER  Dublin Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record review, staff, resident and family interviews, and policy review, the facility failed to ensure scheduled personal hygiene care was consistently provided. This affected two (Resident #32 and #45) out of three dependent residents reviewed for activities of daily living. The facility census was 69. Findings Included: 1. Review of the medical record for Resident #32, revealed an admission date of 01/24/26 with re-entry on 03/01/26. Diagnoses included metabolic encephalopathy, unspecified asthma, aftercare following joint replacement surgery, and difficulty in walking not elsewhere classified. Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status score of 11 indicating moderate cognitive impairment. The assessment indicated the resident required maximal assistance with showering and extensive assistance with other activities of daily living. Review of nursing documentation from 01/24/26 through 02/26/26 revealed Resident #32 had not received any showers during the first week of admission [DATE] - 01/31/26). Subsequent documentation indicated showers were provided on 02/06/26, 02/12/26, 02/19/26, and 02/22/26. All other scheduled showers were either missed or documented as No without notation of refusal, including 02/02/26, 02/08/26, 02/15/26, and 02/20/26. No follow-up interventions, attempts to reschedule, or communication with the family were documented for missed showers. Interview on 03/02/26 at 2:20 P.M., with the Resident #32's spouse revealed the resident had received two showers since admission to his knowledge. He stated on 01/30/26 at 11:00 A.M., he wrote a note indicating his spouse was supposed to be washed up the day before but the washrag was not used. On 03/02/26 at 3:10 P.M., interview with the Director of Nursing (DON) verified no separate shower logs were maintained for Resident #32 and that documentation was completed only in the task area of the electronic record. On 03/03/26 at 8:59 A.M., interview with the Licensed Practical Nurse (LPN) #213 verified Resident #32 was scheduled for showers on Monday and Thursday day shift. The LPN #213 reviewed the task documentation and verified the only documented showers were on 02/06/26, 02/12/26, 02/19/26, and 02/22/26. The LPN #213 verified no refusals were documented for the missed shower dates. 2. Review of the medical record for Resident #45 revealed an admission date of 01/27/26. Diagnoses included other cerebral palsy, moderate persistent asthma uncomplicated, moderate protein-calorie malnutrition, and schizoaffective disorder unspecified. Review of the admission MDS assessment dated [DATE] revealed a Brief Interview for Mental Status score of 13 indicating no cognitive impairment. The assessment indicated the Resident #45 required dependent assistance with showering and toilet hygiene and maximal assistance with additional activities of daily living. Review of the shower task documentation revealed the resident was hospitalized from [DATE] through 02/17/26 and those dates were marked as not available. Documentation indicated the only bath provided from date of admission to 03/04/26 was a bed bath on 02/25/26. No refusals were documented in the progress notes. On 03/02/26 at 8:45 A.M., interview with Resident #45 revealed she stated she had not been bathed since admission. She stated her scheduled showers were Tuesday and Saturday on night shift. She stated that she only received a bed bath on 02/25/26. On 03/03/26 at 8:59 A.M., interview with the LPN #213 verified that if a resident refused a bath it should be documented as a refusal and not (continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>marked as no. LPN #213 verified the only documented bathing for Resident #45 was a bed bath on 02/25/26. Review of the facility policy titled Activities of Daily Living (ADL), Supporting, revised March 2018, revealed residents would be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living. The policy further stated residents who were unable to carry out ADLs independently would receive services necessary to maintain grooming and personal hygiene. The policy indicated appropriate care and services would be provided in accordance with the plan of care, including hygiene such as bathing, dressing, grooming, and oral care. The policy also stated a resident's ability to perform ADLs would be measured using clinical tools including the Minimum Data Set (MDS), and interventions would be monitored, evaluated, and revised as appropriate. This deficiency represents non-compliance investigated under Complaint Number 2736536 and 2790910</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record review, review of the hospital after visit summary, and staff interview, the failed to transcribe and implement hospital discharge orders. This affected one (Resident #21) of three residents reviewed. The facility census was 69. Findings include: Review of the medical record revealed Resident #21 was admitted on [DATE]. Diagnoses included necrotizing fasciitis, acute and chronic respiratory failure, type 2 diabetes, and obstructive and reflux uropathy. Resident #21 was discharged to the hospital on [DATE] and returned 02/27/26. Review of the hospital discharge after visit summary (AVS) for Resident #21 revealed an order dated 02/27/26 for Ciprofloxacin (an antibiotic) 500 milligrams (mg) every 12 hours for 13 doses and an order for vancomycin (an antibiotic) 125 mg four times a day for nine days. Additionally, the AVS revealed an order dated 02/27/26 to discontinue enoxaparin (an anticoagulant) 40 mg per 0.4 milliliters (ml) and hold Metformin (diabetes) 500 mg until 03/02/26. Review of the Medication Administration Record (MAR) for Resident #21 dated February 2026 revealed Ciprofloxacin and vancomycin were not administered. Further review of the MAR dated March 2026 revealed Ciprofloxacin and vancomycin were not administered. Additionally, review of the MAR dated March 2026 revealed enoxaparin was administered once on 03/01/26, 03/02/26, and 03/03/26. Further review revealed Metformin was administered twice on 03/01/26. Interview on 03/03/26 at 2:45 P.M. with Registered Nurse (RN) #178 verified Resident #21 was not taking prescribed antibiotics. Interview on 03/04/26 at 9:37 A.M. with the Director of Nursing (DON) verified Resident #21's orders were not transcribed upon his readmission to the facility on [DATE]. The DON further verified the discharge orders should have been implemented upon Resident #21's return. This deficiency represents non-compliance investigated under Complaint Number 2736536.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record review, review of the hospital discharge summary, review of the self-reported incident (SRI), review of investigative documentation, review of documentation from the contracted company, review of the incident/accident log, and staff interview, the facility failed to ensure adequate supervision and monitoring following intravenous (IV) insertion by a contracted provider. This affected one (Resident #70) out of three residents reviewed for accidents. The facility census was 69. Findings include: Review of the medical record for Resident #70 revealed an admission date of 01/21/26 and a discharge date of 02/01/26. Diagnoses included syncope and collapse, muscle weakness generalized, cognitive communication deficit, expressive language disorder. Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #70 had a Brief Interview for Mental Status score of 12, indicating she was cognitively intact. The assessment indicated the resident required maximal assistance with most activities of daily living and did not receive parenteral or intravenous feeding at that time. Review of the hospital Discharge summary dated [DATE] from OhioHealth revealed the plan included discontinuation of intravenous fluids and encouragement of oral intake. Nursing documentation dated 01/21/26 at 8:05 P.M. indicated a provider order for laboratory testing including complete blood count (CBC) and basic metabolic panel (BMP) due to dehydration concerns. On 01/24/26 at 1:04 P.M., documentation provided by Contract Company #01 indicated intravenous (IV) line placement was completed and signed off at 1:04 P.M. Review of the medical record revealed no documented nursing assessment immediately following the IV line placement to verify removal of the tourniquet or to evaluate the intravenous site. On 01/24/26 at 4:11 P.M., a late entry nursing note documented the resident's Power of Attorney (POA) expressed concern regarding hydration status and requested intravenous fluids. The Director of Nursing (DON) obtained an order for as needed fluids. Documentation indicated the intravenous team was contacted and an intravenous line was placed. The note indicated that the tourniquet was not removed prior to administering intravenous fluid. During a routine assessment, another nurse observed that the tourniquet remained in place on the resident's upper arm. The tourniquet was removed, the provider and family were notified, and a new order for as needed subcutaneous fluids were obtained. On 01/24/26 at 8:00 P.M., a nursing note documented that a peripheral intravenous line was placed in the left arm and intravenous fluids consisting of five percent dextrose in water at 100 milliliters per hour were initiated. The nurse documented that Resident #70's daughter requested assessment of the left arm. The arm was noted as swollen, and a tourniquet was observed on the upper arm. The tourniquet was removed, the arm was elevated, and a cold compress was applied. The daughter declined discontinuation of intravenous fluids at that time. Review of the facility's Self-Reported Incident (SRI) number 270405 related to the event indicated the tourniquet was left in place following intravenous placement. The Self-Reported Incident had not specified the exact time the intravenous line was placed, the time the swelling was identified, or the duration the tourniquet remained in place. The SRI noted the nurse removed the tourniquet once aware of the concern. Review of the facility's investigation revealed conflicting statements regarding the duration the tourniquet remained in place. On 03/02/26 at 12:49 P.M., interview with Registered Nurse (RN) #178 revealed that when the outside companies placed intravenous lines, it was expected that staff assessed the site after placement. He stated there was no defined expectation that the nurse must immediately enter the room after vendor completion. On 03/04/26 at 9:02 A.M., interview with the Administrator revealed that during the investigation for Resident #70's tourniquet being left on, she initially thought it was the floor nurse, RN #238, who left the tourniquet on, which was why the nurse was suspended and education was provided to the nurse. She stated that they later found out it was an outside company, Contract Company #01, but they had not confirmed which company provided the care until 03/03/26. She (continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>stated no education or information was provided to Contract Company #01 to prevent the same situation from happening again. The Administrator verified the facility could not determine the exact timeframe the tourniquet remained on Resident #70's arm and stated they had no sign off documentation indicating when post placement assessment occurred until surveyor intervention on 3/3/26. The Administrator stated that based on documentation review, it was believed the tourniquet was identified within approximately a two hour window, however, this timeframe could not be verified. On 03/04/26 at 9:26 A.M., interview with RN #238 revealed that Contract Company #01 arrived in the late afternoon on 01/24/26 to place the intravenous line. He stated he contacted Contract Company #01 to complete the intravenous placement and received verbal handoff upon completion of the procedure. He reported that after receiving report, he entered the resident's room and initially observed a tourniquet still in place on the resident's arm, which he removed. He stated that shortly thereafter, the resident's daughter alerted him to continued concerns regarding the resident's arm. Upon reentering the room, he observed a second tourniquet remaining on the resident's upper arm, which he then removed. He stated the resident's arm was slightly swollen and he did not observe discoloration. He applied a cold compress to reduce the swelling. He further stated that he had not immediately notify management of the swelling and that management was not aware of the condition of the resident's arm until his next scheduled shift on Tuesday, 01/27/26. He stated he passed the information to the oncoming night shift nurse but acknowledged that no supervisory staff were notified at the time of discovery. He reported that an in-service education was later conducted regarding the situation. Review of the facility documentation revealed no documented evidence of immediate post-procedure assessment following intravenous placement by Contract Company #01. The facility provided documentation of an agreement with Contract Company #01. The facility acknowledged responsibility for the care provided but was unable to produce documentation verifying timely monitoring of the resident after intravenous placement. Review of the incident/accident log verified the event was listed on 01/24/26 and investigated. Documentation indicated the floor nurse was initially suspended during the investigation due to uncertainty regarding responsibility for leaving the tourniquet in place. This deficiency represents non-compliance investigated under Complaint Number 2736536.</p>

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F 0773  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.  **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure laboratory orders and wound cultures were completed timely. This affected one (Resident #71) of three residents reviewed for laboratory tests. The census was 69. Findings include: Review of the medical record for Resident #71 revealed an admission date of [DATE] with diagnoses including a fracture of the right humerus, wedge compression fracture of second lumbar vertebra, multiple fractures of ribs, thrombocytopenia, and hypertension. Resident #71 discharged from the facility on [DATE]. Review of the physician orders revealed an order dated [DATE] for a complete blood count (CBC) and basic metabolic panel (BMP). Further review revealed no evidence the blood tests were completed as ordered. Review of the provider progress notes dated [DATE] revealed labs ordered on [DATE] were not completed. Further review of the physician orders revealed an order dated [DATE] for a CBC and BMP. Review of laboratory testing results revealed the labs were completed as ordered on [DATE]. Review of the physician orders revealed an order dated [DATE] for a wound culture and sensitivity. Review of laboratory reports revealed a wound culture was collected on [DATE] and reported on [DATE]. The laboratory report indicated the test was not performed due to specimen integrity issues, noting that the facility had submitted an expired swab dated [DATE] and instructed the facility to recollect a new wound culture specimen. Further review of the medical record had no documentation that a repeat wound culture was obtained following the notification that the specimen was invalid. Further review revealed a physician order dated [DATE] for a wound culture and sensitivity. Review of laboratory testing results revealed the culture was collected [DATE]. Interview on [DATE] at 1:07 P.M. with the Director of Nursing (DON) verified Resident #71's physician ordered laboratory tests from [DATE] were not completed as ordered. The DON further verified the specimen collection swab used to collect the wound culture on [DATE] was expired and was not recollected until [DATE]. This deficiency represents non-compliance investigated under Complaint Number 2736536.		