STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365365	a. building _____ b. wing _____	06/10/2025

name of provider or supplier	street address, city, state, zip code
URBANA HEALTH & REHABILITATION CENTER	741 E WATER STREET URBANA OH, 43078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000	INITIAL COMMENTS ANNUAL SURVEY COMPLAINT INVESTIGATION MASTER COMPLAINT NUMBER OH00163527 AND COMPLAINT NUMBER OH00162529 ADMINISTRATOR: Tonya Blumenschein, #7454 CERTIFIED BED CAPACITY: 50 CENSUS IN HOUSE: 46 The following deficiencies are based on the annual and complaint surveys completed 06/10/25.	F 0000		

laboratory director's or provider/supplier representative's signature | title | (x6) date

TONYA.BLUMENSCHEIN | 07/14/2025

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.

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F 0550	Continued From page 1	F 0550		
F 0550 SS=D	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion,	F 0550	Urbana Health and Rehab wishes to point out to any person who reviews this document that we do not necessarily agree with the citations with which we were cited. However, the law requires us to prepare a plan of correction for the citations regardless of whether we agree with them or not. Thus, we have prepared such a plan as noted below. Please note though, that this plan does not constitute an admission that the citations are either legally or factually correct. This plan of correction is not meant to establish any standard of care, contract, obligation, or position and Urbana Health and Rehab reserves all rights to raise all possible contentions and defenses in any civil or criminal action or proceeding. Please accept 7/30/25 as the facility's allegation of compliance date. F550 The facility failed to maintain the rights of residents by not providing extra smoke breaks to residents #24, #29, #35 when requested. Step 1: The facility immediately reviewed smoking policy and current smoking schedule, additional smoke added with adjustments of current times. Completed on 6/24/25 Step 2: To identify other residents that have the potential to be affected IDT reviewed current in-house residents that smoke. Completed on 6/24/25 Step 3: To prevent this from recurring the facility IDT will complete updated smoking assessments on current residents choosing to smoke, will have a meeting with the smokers to review the policy, updated smoking times and have noted residents sign updated smoking contracts. Completed on 7/10/25. Step 4: To monitor and maintain ongoing compliance the DON or designee will interview 3 smokers per week x4 weeks then	07/30/2025

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F 0550	Continued From page 2 discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This STANDARD is not met as evidenced by: Based medical record review, observation, staff and resident interview and the facility policy review, the facility failed to honor one resident's (#22) request for a smoking break of one resident reviewed for supervised smoking. The facility identified seven residents who required supervised smoking. In addition the facility failed to timely address and ensure the request for an additional smoke break was resolved for two (#29 and #35) of two residents reviewed for resident rights. The facility census was 46. Findings Included: Review of record for Resident #22 revealed admission date of 07/03/24. Diagnoses included neuromuscular dysfunction of bladder, depression, and nicotine dependence using cigarettes. Review of plan of care dated 08/12/24 revealed Resident #22 had a safe smoking environment by not having smoking violations through next review.	F 0550	monthly x2 months to ensure policy/smoking break compliance and verify new times are working as desired for residents. Audits will begin 7/14/25.	

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F 0550	Continued From page 3 Interventions included staff to keep smoking products, completing smoking assessment, orient and review with resident the smoking policy times, observe clothing and skin for burns, and notify staff immediately if resident was suspected in violating smoking policy. Review of the facility smoking assessment dated 10/29/24 revealed Resident #22 required a supervision during smoke breaks. Interview on 06/05/25 at 8:30 A.M. with Resident #22 revealed who stated that she had never got her smoke break on 06/04/25 which requested from the Social Services (SS) #333 yesterday. Resident #22 stated that she waited on the side of the bed for a half hour, and no staff came to transfer her into a wheelchair and take her to the smoke break. Interview on 06/05/25 at 8:40 A.M. with SS #333 revealed she did not tell any staff to take Resident #22 out for her smoke break. SS #333 stated she had sent a group text out to management with the information. SS #33 stated the resident should have had a smoke break yesterday after she spoke to the resident around 4:15 P.M. and let management staff be aware the resident wanted a smoke break. Interview on 06/05/25 at 8:45 A.M. with Administrator who revealed she was aware that Resident #22 wanted a smoke	F 0550		

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F 0550	Continued From page 4	F 0550		

break on 06/04/25, the Administrator stated she was handling another situation, and thought the smoking need with Resident #22 was resolved.

Review of the facility policy titled "Resident Smoking Policy" dated 06/20/22 revealed the facility had established resident smoking processes that took into account both smoking and non-smoking residents and that comply with applicable federal, state, and local laws and regulation regarding smoking.

2. Medical record review for Resident #29 revealed an admission date of 11/04/18. Her medical diagnoses included a stroke, coronary artery disease, heart failure, hypertension, and diabetes.

Review of the quarterly minimum data set (MDS) dated 04/07/25 revealed Resident #29 was cognitively intact. She was independent for eating, toileting, bed mobility and required a Hoyer lift for transfers. Resident #29 was always incontinent for bowel and bladder.

Review of the facility provided designated smoke times revealed the residents are allowed to smoke at: 9:00 A.M., 11:00 A.M., 1:00 P.M., 4:00 P.M. and 9:00 P.M. daily.

Review of Resident/family Council Agenda/Minutes dated 02/11/25 revealed the council wanted the facility to add another smoke break to the smoke

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F 0550	Continued From page 5 between the times of 4:00 P.M. and 9:00 P.M. Review of Resident/Family Council Agenda/Minutes from 03/02/25, 03/11/25, 03/19/25, 04/08/25, 04/22/25, and 05/13/25 revealed there was no documentation included in the "old business" section of the minutes to address the request of the additional smoke break time from meeting held on 02/11/25, and there was no other concern documented regarding the times of resident smoke breaks on the minutes reviewed. Review of current smoking times for the supervised smokers revealed there wasn't any smoke break time between 4:00 P.M. and 9:00 P.M. Interview with Resident #29 on 06/04/25 at 11:01 A.M. revealed the council had asked for an additional smoking break during the February council meeting and it has not been set up yet. Interview with Activities Director (AD) #236 on 06/04/25 at 1:50 P.M. revealed there wasn't enough staff (even though the smoking times were divided up between other members of staff throughout the facility) to be able to provide another smoking break for the supervised smokers at 7:00 P.M. She revealed she had a new staff member starting on 06/04/25 and she would be trained to take out the supervised	F 0550		

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F 0550	Continued From page 6 smokers at 7:00 P.M. 3. Medical record review for Resident #35 revealed an admission date of 11/09/22. Medical diagnoses included peripheral vascular disease, hypertension, and diabetes. Review of the quarterly MDS dated 05/03/25 revealed Resident #35 was cognitively intact. Her functional status was independent for eating, dependent for toileting, substantial/maximal assistance for bed mobility and she was a Hoyer lift for transfers. She was always incontinent for bowel and bladder. Review of the facility provided designated smoke times revealed the residents are allowed to smoke at: 9:00 A.M., 11:00 A.M., 1:00 P.M., 4:00 P.M. and 9:00 P.M. daily. Review of Resident/Family Council Agenda/Minutes from 03/02/25, 03/11/25, 03/19/25, 04/08/25, 04/22/25, and 05/13/25 revealed there was no documentation included in the "old business" section of the minutes to address the request of the additional smoke break time from meeting held on 02/11/25, and there was no other concern documented regarding the times of resident smoke breaks on the minutes reviewed. Review of resident council minutes dated 02/11/25 revealed the council wanted to	F 0550		

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F 0550	Continued From page 7 add another smoke break to the schedule of smoking times between 4:00 P.M. and 9:00 P.M. Review of current smoking times for the supervised smokers revealed there wasn't any between 4:00 P.M. and 9:00 P.M. Interview with Resident #35 on 06/04/25 at 11:01 A.M. revealed the council had asked for an additional smoking break back in February council meeting and it has not been set up yet. Interview with Activities Director (AD) #236 on 06/04/25 at 1:50 P.M. revealed there wasn't enough staff (even though the smoking times were divided up between other members of staff throughout the facility) to be able to provide another smoking break for the supervised smokers at 7:00 P.M. She revealed she had a new staff member starting on 06/04/25 and she would be trained to take out the supervised smokers at 7:00 P.M. Review of the policy entitled "Residents Rights" not dated revealed the resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.	F 0550		

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F 0557	Continued From page 8	F 0557		
F 0557 SS=D	483.10(e)(2) Respect, Dignity/Right to have Prsnl Property §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This STANDARD is not met as evidenced by: Based medical record review, staff and resident interviews, and facility policy review, the facility failed to ensure staff provided dignity and respect to two residents (#22 and #21) of two residents reviewed for dignity and respect. The facility census was 46. Findings Included: Review of record for Resident #22 revealed admission dated 07/03/24. Diagnoses included neuromuscular dysfunction of bladder, depression, and nicotine dependence using cigarettes. Review of plan of care dated 08/01/24 revealed Resident #22 had risk for altered mood related to depression. Interventions included assisting residents in identify strengths, positive coping skills, anger management, approach in a calm relaxed manner, and collaborative care.	F 0557	F557 The facility failed to maintain the dignity of residents; A) a STNA #206 referred to residents requiring assistance with food and fluid intake as "Feeds", B) a STNA #222 applied a clothing protector on resident #21 prior to asking permission to do so and waiting for a reply, and, as well as C) a STNA #240 made an inappropriate gesture in regard to breasts in the presence of resident #22. Step 1: The facility DON immediately… A) Educated the STNA #206 on the inappropriateness of referring to residents in terms of needs, diagnoses or other identifiable qualifiers, emphasizing the importance of using more appropriate terminology such as "residents requiring assistance with…" on 6/3/25 B) Educated STNA #222 on the need to ask and wait for reply prior to applying items such as clothing protectors to residents and if resident is unable to reply or understand on 6/3/25, IDT to discuss with resident representative and ensure stated desires are care planned Completed on 6/27/25 C) SRI opened and investigation initiated. Completed on 6/10/25 Step 2: To identify other residents that have the potential to be affected… A) DON or designee reviewed current residents that require assistance with oral intake B) DON or designee reviewed current non-verbal and/or cognitively impaired residents that might use clothing protectors during meals C) Resident interviews with interview-able residents and skin sweeps on non-interview-able residents completed with no negative findings (R/T SRI). Completed on 6/27/25 Step 3: To prevent this from recurring… A) DON or designee will educate staff on the	07/30/2025

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F 0557	Continued From page 9 Interview on 06/04/25 at 3:30 P.M. Resident #22 stated that Certified Nursing Assistant (CNA) #240 had a conversation during care, and CNA #240 was inappropriate to her. Resident #22 stated CNA #240 had lifted her own breasts with her hands outside her shirt. Resident #22 stated CNA #240 was trying to be funny, but Resident #22 stated she did not take it as funny. Resident #22 stated this happened a month ago. Interview on 06/04/25 at 3:42 P.M. with CNA #240 who stated she did make a gesture to Resident #22 one time by lifting her breasts with her two hands over her shirt in front of Resident #22 while providing care for her. CNA #240 stated she was trying to be funny and was talking about her breast. Interview on 06/04/25 at 4:10 P.M. with Administrator revealed she would give education to CNA #240 who needed more education, the CNA was written up, and was sent home. Administrator stated it was inappropriate to act this way to a resident at the facility. 2. Medical record review for Resident #21 revealed an admission date of 06/25/21. Medical diagnoses included non-traumatic brain dysfunction. Review of the quarterly Minimum Data	F 0557	inappropriateness of referring to residents in terms of needs, diagnoses or other identifiable qualifiers, emphasizing the importance of using more appropriate terminology such as "residents requiring assistance with…" Completed on 7/11/25 B) DON or designee will educate staff on asking residents permission and waiting for a response prior to applying a clothing protector and for non-verbal residents to verify use on care profile or care plan Completed on 7/11/25 , for non-verbal and/or residents that are unable to respond the DON or designee will contact the residents' responsible party to discuss use of clothing protectors during meals and update the residents' care plans and care profile with responsible party's desires related to the use of clothing protectors Completed 6/27/25. C) LNHA educated current staff on the Abuse, Neglect, and Misappropriation Policy and Procedure. Completed on 6/7/25. STNA #240 was educated by the facility Staffing Coordinator on 6/16/25 prior to returning to work. Step 4: To monitor and maintain ongoing compliance… A) DON or designee will audit 5 staff members per week x4 weeks then monthly x2 months for appropriate responses B) DON or designee will review new admissions for ability to determine desire for clothing protector use and if non-verbal or cognitive impaired will discuss with responsible party then update care plan and profile as indicated in addition to auditing 3 non-verbal/cognitively impaired residents weekly x4weeks then monthly x2 months for clothing protector use in relationship to care planned desires C) DON or designee will	

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F 0557	Continued From page 10 Set (MDS) dated 04/16/25 revealed Resident #21 was severely cognitively impaired with memory problems. Her functional status was dependent for eating, toilet use, bed mobility and she required a Hoyer lift for transfers. The resident was always incontinent for bowel and bladder. Observation on 06/03/25 at 11:00 A.M. revealed Resident #21 was sitting in the dining room in a wheelchair. Certified Nursing Aide (CNA) #222 placed a clothing protector onto the resident and didn't ask or have an interaction with the resident while placing the protector onto the resident. Also during the observation CNA #206 said out loud Resident #21 was the only true feed in the dining room. Interview with CNA #206 on 06/03/25 at 11:05 A.M. confirmed he called Resident #21 the only true feed and could have put it differently. He reported the term "feed" wasn't respectful. Interview with CNA #22 on 06/03/25 at 11:18 A.M. confirmed she should have asked about the clothing protector for Resident #21 and had some kind of interaction with her. Review of the policy entitled "Residents Rights" date unknown revealed that the residents have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside	F 0557	interview 3 resident per week x4 weeks then monthly x2 months to ensure appropriate staff behavior while providing care or in resident areas. Audits will being 7/14/25 The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.	

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F 0557	Continued From page 11 the facility, including those specified. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life.	F 0557		

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F 0565	Continued From page 12	F 0565		
F 0565 SS=E	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups.	F 0565	F565 Urbana Health and Rehab wishes to point out to any person who reviews this document that we do not necessarily agree with the citations with which we were cited. However, the law requires us to prepare a plan of correction for the citations regardless of whether we agree with them or not. Thus, we have prepared such a plan as noted below. Please note though, that this plan does not constitute an admission that the citations are either legally or factually correct. This plan of correction is not meant to establish any standard of care, contract, obligation, or position and Urbana Health and Rehab reserves all rights to raise all possible contentions and defenses in any civil or criminal action or proceeding. Please accept 07/30/25 as the facility's allegation of compliance date. The facility failed to ensure that resident concerns were addressed in a timely manner or resolved affecting resident #24, #35, and #29. Step 1 Concerns that were not addressed for residents #24, #35 and #29 were written on Concern forms by NHA and given to appropriate manager for follow up. This will be completed by 6/30/25. Step 2 Resident Council Minutes were audited back six months by NHA to ascertain any concerns not addressed on 6/30/25. Concern forms were completed and given to appropriate department manager for resolution. Step 3 LED, Life Enrichment staff and all department managers will be educated by LNHA on proper follow up of Resident Council concerns, i.e. proper documentation of the following: education provided, equipment needed, replacement of items etc. This will be completed by 6/30/25 Step 4 To monitor and	07/30/2025

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F 0565	Continued From page 13 §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This STANDARD is not met as evidenced by: Based on review of the Resident Council Minutes, staff and resident interview, and policy review, the facility failed to ensure resident concerns were addressed in a timely manner or resolved. This affected three (#24, #35, #29) of three residents who attended a surveyor led Resident Council Meeting during the annual survey. The facility identified there were 13 residents who regularly attend resident council meetings. This had the potential to affect all of the residents who reside in the facility. The census was 46. Findings included: Review of the Resident Council Minutes from 01/28/25 through 05/13/25 revealed the following concerns were documented on the Resident/Family Council Agenda/Minutes form: 01/28/25 call lights not answered in a timely manner. 02/11/25 residents would like a smoke time added daily at 7:00 P.M. and showers are cold on the A-wing 03/02/25 call lights still not being answered in a timely manner and would like administration to enforce the rules for the staff.	F 0565	maintain ongoing compliance LNHA will audit Resident Council Minutes and Concern forms weekly X4, then monthly x2 to ensure concerns are being resolved timely and appropriately. Results of the audits will be forwarded to the facility QAPI committee for further review and recommendation	

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F 0565	Continued From page 14 03/11/25 staff speaking rudely to residents, asking administration to start addressing complaints. 04/08/25 staff speaking rudely to residents 04/22/25 call lights not answered timely 05/13/25 call lights not answered timely Interview with Resident's #24 (President), #35 (Vice President) and #29 during a surveyor led Resident Council Meeting on 06/04/25 at 11:01 A.M. revealed they didn't feel like complaints were getting addressed in a timely manner by the administration. They revealed the request for an additional smoking break has been going on for months with no resolution. The call lights are not being answered in a timely manner which has been going on for months with no resolution. The shower room on the A-wing is still cold. They further complained about staff being rude to the residents which they have not seen any resolution for. They complained they have wanted to meet without staff present and for a resident to take the minutes of the meeting instead of the staff, but that has not been accommodated either. Interview with Activities Director (AD) #236 on 06/04/25 at 1:50 P.M. confirmed these areas of concern in resident council meetings are not being resolved in a timely manner because the residents are still complaining about them. She confirmed she knew the residents wanted to meet without staff, but a resident had to be trained to record the minutes and she	F 0565		

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F 0565	Continued From page 15 had not been able to complete the resident training. Interview with the Administrator on 06/05/25 at 9:46 A.M. revealed she looked over the Resident/Family Council Agenda/Minutes after each meeting and confirmed the call lights were not resolved even though there were audits completed that proved otherwise. She revealed the staff and the residents who complained about the rudeness from the staff were interviewed and educated on how to treat the residents in a Town Hall Meeting, but there wasn't a concern form to be given to the surveyor. She confirmed the extra smoking time had not been resolved and neither had temperature in the shower in A-wing to the resident's satisfaction. She confirmed the Resident Council was a problem. Review of the policy entitled "Resident Council" dated 07/01/20 revealed the facility recognizes the residents' right to form and participate In group meetings while residing in the facility. The Resident Council Is a resident-oriented group designed for the residents to discuss nursing home standards, offer suggestions for practice guidelines affecting their care and treatment, quality of life, and review of resident rights. The life Enrichment Director or designee may attend the Resident Council Meeting to act as a liaison between the group and the facility if requested by the Council. Any additional facility personnel will attend	F 0565		

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F 0565	Continued From page 16 the meeting upon request of the residents. The Activity Director will attempt to accommodate the resident recommendations to the extent practicable and provide follow-up to the Resident Council. Resident issues or concerns will be documented on the Resident/Family Concern Form and forwarded to the facility Administrator for the appropriate follow-up. Once the respective department has addressed the Resident/Family Concern and document the outcome the form is returned to the Life Enrichment Director to file with the Resident council Meeting Minutes.	F 0565		

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F 0600	Continued From page 17	F 0600		
F 0600 SS=D	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This STANDARD is not met as evidenced by: Based on medical record review, staff and resident interview, resident council meeting, and facility policy review, the facility failed to ensure the residents were safe from abuse. This affected one (#24) of three residents reviewed for abuse. The census was 46. Findings included: Review of the medical record for Resident #24 revealed an admission date of 11/10/22. Medical diagnoses included coronary artery disease, heart failure, diabetes, cerebrovascular accident (CVA) and Non-Alzheimer's disease.	F 0600	F600 Urbana Health and Rehab wishes to point out to any person who reviews this document that we do not necessarily agree with the citations with which we were cited. However, the law requires us to prepare a plan of correction for the citations regardless of whether we agree with them or not. Thus, we have prepared such a plan as noted below. Please note though, that this plan does not constitute an admission that the citations are either legally or factually correct. This plan of correction is not meant to establish any standard of care, contract, obligation, or position and Urbana Health and Rehab reserves all rights to raise all possible contentions and defenses in any civil or criminal action or proceeding. Please accept 07/30/25 as the facility's allegation of compliance date. The facility failed to ensure residents were safe from abuse, affecting one resident #24. Step 1 Resident #24 was assessed and no negative findings. Resident assessment completed on 6/11/25 by NP. STNA #240 was removed from duty and suspended, personnel file for STNA #240 was reviewed for back ground check, along with 5 other random staff personnel files, no concerns were identified. Audit completed on 6/6/25 Step 2 To identify other residents that have the potential to be affected, on 6/6/25 the Social Services initiated interviews of those residents able to be interviewed regarding abuse, completing the interviews on 6/6/25 with no negative findings. DON completed skin check on 6-6-25 for non-verbal and cognitively impaired resident with no negative findings. Step 3 To prevent this from recurring, NHA started in house	07/30/2025

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F 0600	Continued From page 18 Review of the quarterly Minimum Data Set (MDS) dated 04/04/25 revealed Resident #24 was cognitively intact. He was independent assistance for eating, toileting, bed mobility, and transfers. He was always continent of bowel and bladder. Review of a morning meeting form dated 01/14/25 revealed Resident #24 was upset about a resident and wanted him moved to another room and was being inappropriate and screaming at Certified Nursing Aide (CNA) #240 about the new resident. The note revealed CNA #240 was trying to redirect Resident #24 back to his room. During a resident council meeting Resident #24 who was the President of the council on 06/04/25 at 11:01 A.M. revealed a Certified Nursing Aide (CNA) #240 called him an "ass" and he reported it to the Director of Nursing (DON) and she tried to smooth it over because the aide is dating her son who also works in the facility. A subsequent interview with Resident #24 on 06/04/25 at 3:51 P.M. revealed there was a resident who moved across the hall from him and for two nights the resident would moan and groan loudly and Resident #24 wasn't able to get any sleep. He told the CNA #240 she needed to get the resident moved to another room and the aide told him to "quit being an ass". The resident stated he kicked CNA #240 out of his room. He stated the aide is rude to the residents	F 0600	education with all staff regarding elements of abuse to include verbal abuse. Completed on 6/6/25 New hired staff will be educated on abuse policy during orientation. Step 4 To monitor and maintain ongoing compliance the NHA/designee will interview 5 residents weekly x4 then monthly x2 to ensure there are no issues with abuse. The NHA/designee will conduct 5 staff interviews weekly x4 then monthly x2 to validate what to do if they witness or hear abuse. The results of the audits will be submitted to the QAPI committee for further review and recommendations.	

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F 0600	Continued From page 19	F 0600		

and had several complaints on her from the residents. He stated the DON talked to him and tried to cover up the incident and said maybe the aide didn't mean anything by the comment she made and he told the DON to not cover for the aide. He revealed he was angry about the CNA calling him a name and he didn't pay money at the facility to be called names and felt it was abusive. He further revealed no one had asked him for a statement.

Interview with CNA #240 on 06/04/25 at 2:31 P.M. revealed Resident #24 was being rude to her and she told the resident you don't have to be rude to me and admitted she called him an "ass" and changed the statement and said "you don't need to be an ass". She reported she apologized to the resident about the statement and thought it was disrespectful to the resident. She reported it was a mistake on her part for the name she called him.

Interview with the Administrator and DON on 06/04/25 at 2:58 P.M. revealed the Administrator didn't know anything about this incident. The DON said she was in the facility at the time of the incident and the resident was in the hall and he was being inappropriate with the CNA and the aide said to the resident "don't talk to me that way" and the resident continued and the CNA said something about treating people like an "ass" to the resident. The DON reported she took both of them

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F 0600	Continued From page 20 aside and talked with them and they made amends. She reported the resident was inappropriate with staff and continued to have those behaviors. She reported she wanted to make sure her staff stays safe. Review of the policy entitled "Abuse, Neglect and Exploitation" dated 07/11/24 revealed the facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone. Verbal abuse-is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance, regardless of their age, ability to comprehend, or disability.	F 0600		

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F 0609	Continued From page 21	F 0609		
F 0609 SS=D	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This STANDARD is not met as evidenced by: Based on medical record review, staff and	F 0609	F609 Urbana Health and Rehab wishes to point out to any person who reviews this document that we do not necessarily agree with the citations with which we were cited. However, the law requires us to prepare a plan of correction for the citations regardless of whether we agree with them or not. Thus, we have prepared such a plan as noted below. Please note though, that this plan does not constitute an admission that the citations are either legally or factually correct. This plan of correction is not meant to establish any standard of care, contract, obligation, or position and Urbana Health and Rehab reserves all rights to raise all possible contentions and defenses in any civil or criminal action or proceeding. Please accept 07/30/25 as the facility's allegation of compliance date. The facility failed to ensure an allegation of abuse was reported to the state agency affecting resident #24. Step 1 The incident was reported to ODH and investigated by NHA on 6/10/25. Resident #24 was assessed and no negative findings. Assessment completed on 6/11/25 by NP with no negative finding. Step 2 To identify other residents that have the potential to be affected, on 6/6/25 the Social Services initiated interviews of those residents able to be interviewed regarding abuse, completing the interviews on 6/6/25 with no negative findings. DON completed skin check on 6-6-25 for non-verbal and cognitively impaired resident with no negative findings. Step 3 RDCS educated NHA and DON on reporting of all allegations of abuse on 6-6-25. To prevent this from recurring, NHA started immediate in house education with all staff,	07/30/2025

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F 0609	Continued From page 22 resident interview, Resident Council meeting, and facility policy review, the facility failed to ensure an allegation of abuse was reported to the state agency. This affected one (#24) of three residents reviewed for abuse. The census was 46. Findings included: Review of the medical record for Resident #24 revealed an admission date of 11/10/22. Medical diagnoses included coronary artery disease, heart failure, diabetes, cerebrovascular accident (CVA) and Non-Alzheimer's disease. Review of the quarterly Minimum Data Set (MDS) dated 04/04/25 revealed Resident #24 was cognitively intact. He was independent assistance for eating, toileting, bed mobility, and transfers. He was always continent for bowel and bladder. Review of a morning meeting form dated 01/14/25 revealed Resident #24 was upset about a resident and wanted him moved to another room and was being inappropriate and screaming at Certified Nursing Aide (CNA) #240 about the new resident. The note revealed the CNA #240 was trying to redirect Resident #24 back to his room. During a resident council meeting Resident #24 who was the President of the council on 06/04/25 at 11:01 A.M.	F 0609	including management team, regarding reporting of all allegations of abuse. Education will be completed by 6/6/25. New hired staff will be educated on abuse policy during orientation. Step 4 NHA/designee will monitor compliance of reporting to state agency allegation of Abuse, Neglect, Misappropriation weekly X4 then monthly x2. The results of the audits will be submitted to the QAPI committee for further review and recommendations.	

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F 0609	Continued From page 23 revealed a Certified Nursing Aide (CNA) #240 called him an "ass" and he reported it to the Director of Nursing (DON) and she tried to smooth it over because the aide is dating her son who also works in the facility. A subsequent interview with Resident #24 on 06/04/25 at 3:51 P.M. revealed there was a resident who moved across the hall from him and for two nights the resident would moan and groan loudly and Resident #24 wasn't able to get any sleep. He told the CNA #240 she needed to get the resident moved to another room and the aide told him to "quit being an ass". The resident stated he kicked the CNA #240 out of his room. He stated the aide is rude to the residents and had several complaints on her from the residents. He stated the DON talked to him and tried to cover up the incident and said maybe the aide didn't mean anything by the comment she made and he told the DON to not cover for the aide. He revealed he was angry about the CNA calling him a name and he didn't pay money at the facility to be called names and felt it was abusive. He further revealed no one had asked him for a statement. Interview with CNA #240 on 06/04/25 at 2:31 P.M. revealed Resident #24 was being rude to her and she told the resident you don't have to be rude to me and admitted to she called him an "ass" and changed the statement and said "you don't need to be an ass". She reported she apologized to the resident about the	F 0609		

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F 0609	Continued From page 24 statement and thought it was disrespectful to the resident. She reported it was a mistake on her part for the name she called him. Interview with the Administrator and DON on 06/04/25 at 2:58 P.M. revealed the Administrator didn't know anything about this incident and it couldn't be reported to the state agency. The DON said she was in the facility at the time of the incident and the resident was in the hall and he was being inappropriate with the CNA and the aide said to the resident "don't talk to me that way" and the resident continued and the CNA said something about treating people like an "ass" to the resident. The DON reported she took both of them aside and talked with them and they made amends. She reported the resident was inappropriate with staff and continues to have those behaviors. She reported she wanted to make sure her staff stays safe. Review of the policy entitled "Abuse, Neglect and Exploitation" dated 07/11/24 revealed facility staff must immediately report all such allegations to the Administrator/Abuse Coordinator. The Administrator/Abuse Coordinator will immediately begin an investigation and notify the applicable local and state agencies in accordance with the procedures in this policy.	F 0609		

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F 0610	Continued From page 25	F 0610		
F 0610 SS=D	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This STANDARD is not met as evidenced by: Based on medical record review, staff and resident interview, resident council meeting, and facility policy review, the facility failed to ensure an investigation was initiated for a allegation of abuse. This affected one (#24) of three residents reviewed for abuse. The census was 46. Findings included: Review of the medical record for Resident	F 0610	F610 Urbana Health and Rehab wishes to point out to any person who reviews this document that we do not necessarily agree with the citations with which we were cited. However, the law requires us to prepare a plan of correction for the citations regardless of whether we agree with them or not. Thus, we have prepared such a plan as noted below. Please note though, that this plan does not constitute an admission that the citations are either legally or factually correct. This plan of correction is not meant to establish any standard of care, contract, obligation, or position and Urbana Health and Rehab reserves all rights to raise all possible contentions and defenses in any civil or criminal action or proceeding. Please accept 7/30/25 as the facility's allegation of compliance date. The facility failed to follow Ohio Resident Abuse Policy and ensure an investigation was initiated for an allegation of abuse affecting resident #24. Step 1 Alleged perpetrator was suspended on 6/4/25 pending investigation results. Resident #24 was assessed and no negative findings. Assessment completed on 6/11/25 by NP with no negative findings. Step 2 To identify other residents that have the potential to be affected, on 6/6/25 the Social Services initiated interviews of those residents able to be interviewed regarding abuse, completing the interviews on 6/6/25 with no negative findings. DON completed skin checks on 6-6-25 for non-verbal and cognitively impaired resident with no negative findings. Step 3 RDCS educated NHA and DON on reporting of all allegations of abuse on 6-6-25. To prevent this from recurring, NHA started	07/30/2025

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F 0610	Continued From page 26 #24 revealed an admission date of 11/10/22. Medical diagnoses included coronary artery disease, heart failure, diabetes, cerebrovascular accident (CVA) and Non-Alzheimer's disease. Review of the quarterly Minimum Data Set (MDS) dated 04/04/25 revealed Resident #24 was cognitively intact. He was independent for eating, toileting, bed mobility, and transfers. He was always continent of bowel and bladder. Review of a morning meeting form dated 01/14/25 revealed Resident #24 was upset about a resident and wanted him moved to another room and was being inappropriate and screaming at Certified Nursing Aide (CNA) #240 about the new resident. The note revealed the CNA #240 was trying to redirect Resident #24 back to his room. During a resident council meeting on 06/04/25 at 11:01 A.M. Resident #24, who was the President of the council, revealed Certified Nursing Aide (CNA) #240 called him an "ass" and he reported it to the Director of Nursing (DON) and she tried to smooth it over because the CNA is dating her son who also works in the facility. A subsequent interview with Resident #24 on 06/04/25 at 3:51 P.M. revealed there was a resident who moved across the hall from him and for two nights the resident would moan and groan loudly and Resident #24 wasn't able to get any sleep. He told CNA #240 she needed	F 0610	immediate in house education with all staff regarding Abuse Policy and the investigation of all allegations of abuse. Education will be completed by 6/6/25 New hired staff will be educated on abuse policy during orientation. Step 4 NHA/designee will monitor compliance of investigating allegation of Abuse, Neglect, Misappropriation weekly X4 then monthly x2. The results of the audits will be submitted to the QAPI committee for further review and recommendations.	

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F 0610	Continued From page 27 to get the resident moved to another room and the aide told him to "quit being an ass". The resident stated he kicked CNA #240 out of his room. He stated the aide is rude to the residents and had several complaints on her from the residents. He stated the Director of Nursing (DON) talked to him and tried to cover up the incident and said maybe the aide didn't mean anything by the comment she made and he told the DON to not cover for the aide. He revealed he was angry about the CNA calling him a name and he didn't pay money at the facility to be called names and felt it was abusive. He further revealed no one had asked him for a statement. Interview with CNA #240 on 06/04/25 at 2:31 P.M. revealed Resident #24 was being rude to her and she told the resident you don't have to be rude to me and admitted to she called him an "ass" and changed the statement and said "you don't need to be an ass". She reported she apologized to the resident about the statement and thought it was disrespectful to the resident. She reported it was a mistake on her part for the name she called him. Interview with the Administrator and DON on 06/04/25 at 2:58 P.M. revealed the Administrator didn't know anything about this incident and did not initiate an investigation. The DON said she was in the facility at the time of the incident and the resident was in the hall and he was	F 0610		

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F 0610	Continued From page 28 being inappropriate with the CNA and the aide said to the resident "don't talk to me that way" and the resident continued and the CNA said something about treating people like an "ass" to the resident. The DON reported she took both of them aside and talked with them and they made amends. She reported the resident was inappropriate with staff and continues to have those behaviors. She reported she wanted to make sure her staff stays safe. She didn't have any interviews from staff or residents regarding the incident and didn't take a statement from the CNA or the resident. Review of the policy entitled "Abuse, Neglect and Exploitation" dated 07/11/24 revealed it was the facility's policy to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, exploitation of residents, misappropriation of resident property and injuries of unknown source.	F 0610		

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F 0644	Continued From page 29	F 0644		
F 0644 SS=D	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to complete a Preadmission Screening and Resident Review (PASRR) for residents who had hospice services. This affected two residents, (Residents #3 and #14) of two residents reviewed for hospice services. The facility census was 46. Findings Include:	F 0644	F644 Urbana Health and Rehab wishes to point out to any person who reviews this document that we do not necessarily agree with the citations with which we were cited. However, the law requires us to prepare a plan of correction for the citations regardless of whether we agree with them or not. Thus, we have prepared such a plan as noted below. Please note though, that this plan does not constitute an admission that the citations are either legally or factually correct. This plan of correction is not meant to establish any standard of care, contract, obligation, or position and Urbana Health and Rehab reserves all rights to raise all possible contentions and defenses in any civil or criminal action or proceeding. Please accept 7/30/25 as the facility's allegation of compliance date. The facility failed to ensure that PASRR were completed for residents #14 and #3 regarding significant changes in condition and hospice enrollment. Step 1 Social Services promptly completed PASRRs on residents #14 ad #3 for their significant change in condition. Completed on 6/12/25 Step 2 Social Services to complete an audit on all resident in the last year who have significant changes and admitted to hospice services. Completed on 6/26/25 Step 3 LNHA to provide education to IDT on process of discussing residents with significant change and possible hospice admission at morning clinical meeting, weekly resident review, and weekly PASRR meeting. Education completed by 6/30/25 Step 4 To monitor and maintain ongoing compliance LNHA will audit PASRR weekly log and MDS Sig Changes assessments weekly X4, then monthly x2 to	07/30/2025

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F 0644	Continued From page 30 1. Record review of Resident #3 revealed the resident was admitted to the facility on 08/07/23. Diagnoses for Resident #3 include dementia, anxiety, stage four kidney disease, heart disease, and shortness of breath. Review of the Minimum Data Set, (MDS) comprehensive assessment dated 05/13/25 revealed the resident had intact cognition and was dependent on staff for transfers and mobility. The resident received hospice services starting on 11/23/24. Review of Preadmission Screening and Resident Review (PASRR) records for Resident #3 revealed no PASRR was completed when hospice services were initiated for the resident. 2. Record review of Resident #14 revealed the resident was admitted to the facility on 05/18/20. Diagnoses for Resident #14 include dementia, anxiety disorder, dysphagia, repeated falls, malnutrition, anemia, muscle weakness, and osteoporosis. Review of the Minimum Data Set, (MDS) comprehensive assessment dated 05/15/25 revealed the resident had severely impaired cognition and was dependent on staff for all Activities of Daily Living skills, except the resident required assistance with feeding. Resident #14 had orders for hospice	F 0644	ensure PASRRs are being completed for residents with Sig Changes and admissions to hospice. Results of the audits will be forwarded to the facility QAPI committee for further review and recommendation	

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F 0644	Continued From page 31 services beginning on 12/17/24. Review of Preadmission Screening and Resident Review (PASRR) records for Resident #3 revealed no PASRR was completed when hospice services were initiated for the resident. Interview on 06/09/25 at 10:52 A.M. with Social Service Designee, (SSD) # 333 verified there were no additional PASRR records for Resident #3 or Resident #14, and neither resident had a PASRR completed when the resident had a significant change was was admitted to hospice services.	F 0644		

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F 0657	Continued From page 32	F 0657		
F 0657 SS=D	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This STANDARD is not met as evidenced by: Based on medical record review, staff and	F 0657	F0657 Urbana Health and Rehab wishes to point out to any person who reviews this document that we do not necessarily agree with the citations with which we were cited. However, the law requires us to prepare a plan of correction for the citations regardless of whether we agree with them or not. Thus, we have prepared such a plan as noted below. Please note though, that this plan does not constitute an admission that the citations are either legally or factually correct. This plan of correction is not meant to establish any standard of care, contract, obligation, or position and Urbana Health and Rehab reserves all rights to raise all possible contentions and defenses in any civil or criminal action or proceeding. Please accept 07/30/25 as the facility's allegation of compliance date. The facility failed to ensure residents #29 and #39 received routine care conferences. Care conference to be scheduled with residents #29 on 7/18/25 7 days following her Comprehensive assessment and care conference held 6/19/25 for resident #39. Step 2 NHA will audit the care conference schedule and compare to Comprehensive assessments and make adjustments to the care conference schedule as necessary by 6/30/25. Step 3 Social Services will be educated by LNHA on process of scheduling care conferences timely in accordance with Comprehensive assessment schedule. Education completed by 6/30/25. Step 4 Administrator will monitor compliance by auditing Care Conference completion weekly x4 weeks, then monthly x2 months. The results of the audits will be submitted to the QAPI committee for further	07/30/2025

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F 0657	Continued From page 33 resident interview, review of the care conferences and facility policy review, the facility failed to ensure residents received routine care conferences. This affected two (#29 and #39) of three residents reviewed for care conferences. The census was 46. Findings included: 1. Medical record review for Resident #29 revealed an admission date of 11/04/18. Medical diagnoses included coronary artery disease, heart failure, hypertension, and diabetes. Review of the care conferences for Resident #29 revealed there were documented care conferences on 10/10/24 and on 02/27/25. Review of the quarterly MDS dated 04/07/25 revealed Resident #29 was cognitively intact. Interview with the Resident #29 on 06/03/25 at 11:25 A.M. revealed she had not had a care conference every three months. Interview with Social Services Designee (SWD) #214 on 06/05/25 at 10:01 A.M. revealed she was supposed to complete care conferences every three months and she was running behind. 2. Medical record review for Resident #39	F 0657	review and recommendations.	

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F 0657	Continued From page 34 revealed an admission date of 10/26/23. Medical diagnoses included heart failure, coronary artery disease, peripheral vascular disease, and renal insufficiency. Review of the care conferences revealed Resident #39's last care conference was on 10/17/24. Review of the quarterly Minimum Data Set (MDS) dated 05/03/25 revealed Resident #39 was cognitively intact. Interview with Resident #39 on 06/03/25 at 12:03 P.M. reported she didn't remember having a care conference every three months. Interview with Social Services Designee (SSD) #214 on 06/04/25 at 10:01 A.M. confirmed she was supposed to complete care conferences every three months and she was behind. Review of the policy entitled "Comprehensive Care Planning Policy" dated 03/20/25 revealed the care plan is reviewed on an ongoing basis and revised as indicated by the resident's needs, wishes, or a change in condition. At a minimum, this will occur with each comprehensive and quarterly assessment in accordance with Resident Assessment Instrument (RAI) requirements.	F 0657		

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F 0689	Continued From page 35	F 0689		
F 0689 SS=D	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This STANDARD is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure a safe homelike environment was free on unsecured potential poisonous chemicals. This affected one (#37) of 46 residents observed in the facility for potential hazards. The facility census was 46. Findings included: Observations on 06/02/25 through 06/04/25 from 9:45 A.M. to 3:30 P.M., revealed the following environmental issues. The shower room closet located in the short A unit hallway had a closure which was easily unlocked and had a bottle labeled disincentive chemical cleaner. The warning label stated to "keep out of the reach of children". In the unlocked B hall unit shower room, there was a gallon size container, with a	F 0689	F689 The facility failed to maintain an environment free from accident hazard when unsecured cleaning chemicals where observed in the B Wing Shower Room and in a closet outside of the A Wing Shower Room. Step 1: The facility DOM immediately removed the chemicals from the B Wing Shower Room and placed a lock on the closet outside of the A Wing Shower Room. Completed on 6/10/25 Step 2: This has the potential to effect 3 residents, #37, #14 and #4, who are known to wander throughout the facility. The facility DON assessed identified residents with no negative findings. Completed on 6/11/25 Step 3: To prevent this from reoccurring the DON or designee will educate staff on the need to keep chemicals in a secure location when not in use. Completed on 7/11/25 Step 4: To monitor and maintain ongoing compliance the DON or designee will audit shower rooms and closets 3 times per week x 4 weeks then monthly x2 to ensure cleaning chemicals are secure. Audits will begin on 7/14/25 The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.	07/30/2025

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F 0689	Continued From page 36 nozzle sprayer and tubing attached, on the floor. It contained a clear liquid. There was no label on the container to identify the liquid. Observations from 06/09/25 from 9:45 A.M through 3:30 P.M. revealed Resident #37 wandering in hallways, rooms and common areas, including the A and B units hallways. Record review of Resident #37 revealed the resident was admitted to the facility on 06/28/21. Diagnosis for Resident # 37 included dementia, insomnia, and cognitive communication deficit. The resident wore a monitor device for elopement monitoring. Review of the Minimum Data Set, (MDS) comprehensive assessment dated 03/31/25 revealed the resident had severely impaired cognition and ambulated without assistance devices. Interview on 06/05/25 at 7:30 A.M., the Maintenance Director, (MD) # 202 verified the unlocked closet with chemical and unlabeled gallon sprayer in the unlocked unit B shower room. He stated all chemicals should be stored with a locks a resident could not open. He stated he could not identify the clear liquid as it was unlabeled, and all containers must be labeled.	F 0689		

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F 0692	Continued From page 37	F 0692		
F 0692 SS=D	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This STANDARD is not met as evidenced by: Based on observation, medical record review, staff and resident interview, the facility failed to ensure a restricted liquid diet was honored. This affected one (#39) of two reviewed for hydration during the annual survey. The census was 46. Findings include:	F 0692	F692 The facility failed to follow resident #198 fluid restriction as ordered and failed to document/care plan resident refusal/non-compliance. Step 1: The facility ADON immediately removed additional ice water at bedside and updated resident's fluid restriction order to include documentation if resident is non-compliant, and care plan updated for resident #198. Completed on 6/9/25 Step 2: To identify other residents that have the potential to be affected DON or designee reviewed all residents with fluid restriction orders as well as their corresponding care plans for accuracy. Completed on 6/9/25 Step 3: To prevent this from recurring the DON or designee will educate staff on fluid restrictions including orders, non-compliance, fluid break downs and need for proper documentation. Completed on 7/11/25 Step 4: To monitor and maintain ongoing compliance DON or designee will audit fluid restriction orders, care plans and documentation weekly x4 weeks then monthly x2 months. Audits will being 7/14/25 The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.	07/30/2025

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F 0692	Continued From page 38 Medical record review for Resident #39 revealed an admission date of 10/26/23. Medical diagnoses included heart failure, coronary artery disease, peripheral vascular disease, and renal insufficiency. Review of the quarterly Minimum Data Set (MDS) dated 05/03/25 revealed Resident #39 was cognitively intact. Her functional status was independent for eating, toileting, bed mobility, and setup or clean-up assistance for transfers. She was always continent for bowel and bladder. Review of the physician's order dated 04/30/25 revealed Resident #39 was on a fluid restriction to give 1200 cubic centimeters (cc) for a 24-hour period. Dietary to give 840 cc's total, for breakfast 360 cc's, for lunch 240 cc's, and dinner 240 cc's. Observation of Resident #39's lunch tray on 06/03/25 at 12:00 P.M. revealed she had 240 cc's of water and 240 cc's of iced tea for a total of 480 cc's. Further observation of a breakfast tray on 06/05/25 revealed she had 240 cc's of milk, 240 cc's of coffee and 120 cc's of orange juice for a total of 600 cc's. Interview with Resident #39 on 06/03/25 at 12:12 P.M. revealed she was on a fluid restriction and sometimes the meals have too many fluids on them for consumption.	F 0692		

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F 0692	Continued From page 39 Interview with the Dietary Cook (DC) #250 on 06/05/25 at 7:33 A.M. confirmed Resident #39 was on a fluid restriction and she confirmed she placed 600 cc's of fluids on her breakfast tray and should have only put 360 cc's on the tray for consumption. Interview with Registered Nurse (RN) #204 on 06/09/25 at 10:45 A.M. revealed there are times Resident #39 gets too much to drink on her meal trays.	F 0692		

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F 0759	Continued From page 40	F 0759		
F 0759 SS=E	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This STANDARD is not met as evidenced by: Based on observation, record review, staff interview, and facility policy review, the facility failed to have a medication error rate less than five percent. This affected two residents (#15 and #43) of three residents observed for medication administration. The facility census was 46. Findings Included: Observation on 06/04/25 of medication pass revealed 30 opportunities were observed with two errors for a medication error rate of 6.67%. 1. Review of medical records for Resident #43 revealed an admission date 07/18/24. Diagnoses included chronic obstructive pulmonary disease, osteoporosis, pneumonia, paroxysmal atrial fibrillation. Review of the Quarterly Minimum Data Set (MDS) dated 04/25/25 revealed Resident #43 had Brief Interview of Mental Status (BIMS) score of 15 that indicated he was cognitively intact. Review of the plan of care dated 11/25/23 revealed that Resident #43 had problems	F 0759	F759 Facility observed medication administration error rate of 6.75% effecting residents #43 and #15, when LPN administered Senna Plus to resident #43 instead of ordered Senna and RN crushed potassium chloride for resident #15. Step 1: The facility RN #204 immediately notified the PCP with no new orders on 6/4/25. Residents #43 was assessed by the facility DON with no negative findings and resident #15 was assessed by RN #204 without negative effects observed on 6/4/25. The LPN #257 and RN #204 were immediately educated by the facility DON on medication administration principles as well as medication error prevention. Completed on 6/5/25 Step 2: All residents have the potential to be affected by medication error rate of 6.75%. Step 3: To prevent this from recurring the DON or designee will educate licensed nursing personal on principles of proper medication administration, including medications that can/cannot be crushed and medication error prevention as well as having updated medication administration competencies. Completed on 7/11/25 Step 4: To monitor and maintain ongoing compliance the DON or designee will complete medication administration audits 2x per week x4 weeks then 2x per month x2 months. Audits will begin on 7/14/25 The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.	07/30/2025

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F 0759	Continued From page 41 with elimination and bowel constipation related to use of pain medications. Interventions included encourage fluids, administration medication as ordered, and diet as ordered. Review of physician order dated 12/20/24 revealed Resident #43 had an order for Sennoside 8.6 milligram (mg) give two tablets for constipation twice a day. Observation on 06/04/25 at 7:37 A.M. of medication pass with Licensed Pratical (LPN) #257 who prepared medication for Resident #43. LPN #257 prepared and administered Senna Plus 8.6-50 mg two tablets to Resident #43 with his morning medication. Interview on 06/04/25 at 1:00 P.M. with LPN #257 it was verified that she did give Resident #43 the wrong medication of Senna Plus 8.6-50 mg instead of Sennoside 8.6 mg the resident had ordered. 2. Review of medical record for Resident #15 revealed an admission date 08/21/24. Diagnoses included chronic diastolic heart failure, depression, vascular dementia, paroxysmal atrial fibrillation, and hypertension. Review of quarterly MDS dated 04/25/25 revealed a BIMS score of one indicating the resident was severely cognitively impaired. Review of physician order dated 09/22/24 revealed Resident #15 had an order for	F 0759		

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F 0759	Continued From page 42 Potassium Chloride extended release (ER) (electrolyte supplement) 20 milliequivalent (MEQ) one tablet once a day. Observation on 06/04/25 at 8:00 A.M. with Registered Nurse (RN) #204 who was preparing medication for next Resident #15 revealed the RN prepared and administered Amiodarone 200 mg, Calciumn (supplement) 600 mg with Vitamin D 3, Citalopram (antidepressant) 20 mg, Depakote Sodium (anticonvulsant used for mood stabalization) 125 mg, Eliquis (blood thinner)5 mg, Lasix (diuretic) 40 mg, Gabapentin (anticonvulsant) 200 mg, Lansoprazole (proton pump inhibitor) 30 mg, Metoprolol (used to treat high blood pressure) 25 mg, Senna-Plus (laxative) 8.6-50 mg, and Potassium 20 Milliequivalent and crushed all medication. RN #204 placed all medication powder into applesauce. RN #204 headed to Resident #15 room, then verified she crushed all of Resident #15 medication. RN #204 gave Resident #15 her crushed medication including Potassium Chloride 20 ER MEQ. Interview on 06/04/25 at 1:19 P.M. with RN #204 who verified that Resident #15 who had Potassium Chloride ER 20 MEQ crushed and placed in applesauce and administered to the resident. Review of the facility policy titled "General Dose Preparation and Medication Administration" date 11/15/24 revealed	F 0759		

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F 0759	Continued From page 43 prior to preparing or administering medications, authorized and competent facility staff should follow facility's infection control policy. The facility should not leave medications or chemicals unattended. Facility staff should avoid touching the medications with bare hands when opening a bottle or unit dose package. Facility staff should verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident.	F 0759		

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F 0760	Continued From page 44	F 0760		
F 0760 SS=D	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This STANDARD is not met as evidenced by: Based on record, observation, interview, pharmacy interview, policy, the facility failed to provide safe delivery of medication by crushing potassium 20 Milliequivalent for one resident (#15) out of residents reviewed on annual. The facility census was 46. Findings Included: Review of record revealed that Resident #15 had admission date 08/21/24. Diagnoses included chronic diastolic heart failure, depression, vascular dementia, paroxysmal atrial fibrillation, and hypertension. Review of Quarter MDS dated 04/25/25 revealed that BIMS was 1 that indicated she was severely cognitively impaired. Review of plan of care dated 08/21/24 revealed that Resident #15 had a risk for cardiac that had arteriosclerotic heart disease. Intervention was to provide small meals or frequent rather than three large meals, encourage activity level, and administer medications as ordered. Review of physician order dated 08/21/24 revealed that Resident #15 had an order to crush medications unless	F 0760	F760 Facility failed to prevent significant medication administration error for resident #15, when RN #204 crushed potassium chloride for resident #15. Step 1: The facility RN #204 immediately notified the PCP; No new orders. The RN #204 assessed resident # 15 without negative effects observed. The RN #204 was immediately educated by the DON on medication administration principles as well as medication error prevention with special focus on medications that cannot be crushed. Completed on 6/5/25 Step 2: This has the potential to affect residents that require medications being crushed. The DON will review medication lists for residents that require mechanically altered medications on 7/10/25 Step 3: To prevent this from recurring the DON or designee will educate licensed nursing personal on principles of proper medication administration and medication error prevention with special focus on medications that cannot be crushed. Completed on 7/11/25 Step 4: To monitor and maintain ongoing compliance the DON or designee will complete medication administration audits 2x per week x4 weeks then 2x per month x2 months. Audits will begin 7/14/25 The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.	07/30/2025

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F 0760	Continued From page 45 contraindicated. Review of physician order dated 09/22/24 revealed that Resident #15 had an order for Potassium Chloride extended release 20 milliequivalent one tablet once a day. Observation on 06/04/25 at 8:00 A.M. with Registered Nurse (RN) #204 who was preparing medication for next Resident #15. RN #204 took all medication including Amiodarone 200 mg, Calcium 600 mg with Vitamin D 3, Citalopram 20 mg, Depakote Sodium 125 mg, Eliquis 5 mg, Lasix 40 mg, Gabapentin 200 mg, Lansoprazole 30 mg, Metoprolol 25 mg, Senna-Plus 8.6-50 mg, and Potassium 20 Milliequivalent (MEQ) and crushed all medication. Interview on 06/04/25 at 1:19 P.M. with RN #204 who verified that Resident #15 who had Potassium extended release 20 Milliequivalent (MEQ) and placed in applesauce and gave her. Interview on 06/04/25 at 2:31 P.M. with Pharmacist #399 who stated that you are never to crush potassium chloride 20 MEQ with a pill form that was extended release. Review of the facility document titled "Common Oral Dosage Forms That Should Not Be Crushed" dated year 2023 revealed that Potassium K tablet extended release was not to be crushed.	F 0760		

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F 0760	Continued From page 46 Review of the facility policy titled "General Dose Preparation and Medication Administration" date 11/15/24 revealed that the prior to preparing or administering medications, authorized and competent facility staff should follow facility's infection control policy. The facility should not leave medications or chemicals unattended. Facility staff should avoid touching the medications with bare hands when opening a bottle or unit dose package.	F 0760		

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F 0761	Continued From page 47	F 0761		
F 0761 SS=D	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This STANDARD is not met as evidenced by: Based on record review, observation, staff interview, and facility policy review, the facility failed to ensure medications were not expired and the facility failed to	F 0761	F761 The facility failed to ensure to A) proper storage and handling of medications when medications were observed at the bedside of resident #28. B) Failed to remove seven bottles of expired Folic Acid from the OTC medication storage cabinet. Step 1: The facility RN Supervisor immediately A) secured the medications noted at bedside of resident #28, notified the PCP with no new orders and assessed the effected resident with no negative findings. The RN #241 responsible for not properly securing (leaving at bedside) said medications was educated and disciplined by the DON. Completed on 6/2/25 B) The facility DON removed the expired folic acid from storage and disposed of on 6/4/25. Step 2: This has the potential to affect all residents; current medications in stock were audited for expiration dates and proper storage/properly secured by the DON on 6/13/25 with no negative findings. Step 3: To prevent this from recurring the DON or designee will educate licensed nurses and the Central Supply Designee on the proper policy and procedure for labeling, securing, storage, handling and (for nurses) administration of medications and biologic agents. Completed on 7/11/25 Step 4: To monitor and maintain ongoing compliance the DON or designee will audit medications for proper labeling, storage and handling 2x per week x4 weeks then 2x per month x2 months. Audits will begin 7/14/25 The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.	07/30/2025

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F 0761	Continued From page 48 provide safe storage and delivery of medication for one resident (#28). The facility census was 46. Findings Included: Observation on 06/04/25 at 8:40 A.M. of the overstock medication room, revealed there were seven bottles of Folic Acid 400 micrograms (mcg) with an expiration date was 02/2025. Interview on 06/04/25 at 8:40 A.M. with Registered Nurse (RN) #204 it was verified the seven bottles of Folic Acid 400 mcg expired 02/2025. Each bottle was unopened and contained 250 tablets. Review of the facility document titled "In House Stock" dated unknown revealed that the facility did have Folic Acid 400 micrograms (mcg) over the counter for stock. Review of the facility policy titled "Storage and Expiration Dating of Medications and Biological's" dated 08/01/24 revealed the facility should ensure medications and biological's are stored in an orderly manner in cabinets, drawers, carts, refrigerators, and freezers of sufficient size to prevent crowding. The facility should destroy or return all discontinued, outdated or expired, or deteriorated medications or biological's in accordance with pharmacy return/destruction guidelines and other applicable laws, and in accordance with the policy.	F 0761		

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F 0761	Continued From page 49 2. Record review for Resident #28 revealed the resident was admitted to the facility on 05/16/23. Diagnoses for Resident #28 include diabetes, cerebral infarction, edema, symbolic dysfunctions, and hypertension. Review of the Minimum Data Set, (MDS) comprehensive assessment dated 04/07/25 revealed the resident had intact cognition and was independent in Activities of Daily Livings (ADL) skills. The resident had physician orders for oral Hydralazine (used to treat high blood pressure)50 milligrams three times a day at 3:00 A.M. - 5:00 A.M., 1:00 P.M.- 4:00 P.M. , and 7:00 P.M. - 11:00 P.M. for hypertension . Review of the June 2025 Medication Administration Record, (MAR) revealed Resident #28 received Hydralazine 50 milligrams signed by Registered Nurse, (RN) #241. Observation on 06/02/25 at 9:45 A.M. of Resident #28's room revealed the resident was not in the room and there was pink/orange pill inside the pill cup on the bedside table of Resident #28. Interview on 06/02/25 at 9:46 A.M. with RN #204 verified there was a pill cup with a pink/orange pill on the bedside stand of Resident #28. RN #204 identified the pill	F 0761		

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F 0761	Continued From page 50 as Hydralazine and verified the medication should have been given on 06/02/25 at 3:00 A.M. -5:00 A.M. of by the night shift nurse. Review of the June MAR with RN #204 verified the dose was documented as administered by the night shift nurse. RN #204 verified when administering medications the nurse must observe the resident taking the medication and not to leave the medication at the bedside. Interview on 06/02/25 at 10:30 A.M. Resident #28 revealed she is not always watched by the evening nurse when she takes her medications as sometimes she is sleepy and the medication is left on the bedside table by the nurse. Resident #28 verified the pill was in the pill cup this morning when she woke up.	F 0761		

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F 0791	Continued From page 51	F 0791		
F 0791 SS=D	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's	F 0791	F791 The facility failed to secure and follow up on an oral surgeon appointment for resident #29. Step 1: The facility ADON immediately assessed resident #29 with no negative effects noted. Completed on 6/13/25. Step 2: To identify other residents that have the potential to be affected the DON or designee will audit resident medical records for residents seen by the facility dental provider (360 care) for any residents that might have had a referral for follow up care with outside dental services. Completed on 6/27/25 with no negative findings. Resident #29 scheduled for oral surgeon consult at the Cleveland Dental Inst. 7/31/25 at 11am. Step 3: To prevent this from recurring, the facility DON will educate staff involved with resident appointments that if the facility scheduler or designee is unable to find dental services due to insurance being out of network for the resident, the facility will make arrangements to get the cost of dental services covered. Completed on 7/11/25 Step 4: To monitor and maintain ongoing compliance the DON or designee will audit dental needs, including services and needed follow up weekly x4 weeks then monthly x2 months. Audits will begin 7/14/25 The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.	07/30/2025

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F 0791	Continued From page 52 responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This STANDARD is not met as evidenced by: Based on medical record review, staff and resident interview and facility policy review, the facility failed to ensure a follow-up appointment was made for a resident who had a tooth that was broke off at the gum line. This affected one (#29) of four residents reviewed for dental services during the annual survey. The census was 46. Findings included: Medical record review for Resident #29 revealed an admission date of 11/04/18. Medical diagnoses included a stroke, coronary artery disease, heart failure, hypertension, and diabetes. Review of the quarterly Minimum Data Set (MDS) dated 04/07/25 revealed Resident #29 was cognitively intact. She was independent for eating, toileting, bed mobility and she required a Hoyer lift for transfers. She was always incontinent for bowel and bladder.	F 0791		

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F 0791	Continued From page 53 Review of the resident's dental appointment dated 09/09/24 revealed the dentist tried to extract her tooth and the root was under the gum line and it wouldn't come out. He spoke to Social Services Designee (SSD) and Director of Nursing (DON) about the appointment and the new treatment plan. There was an extraction needed for this tooth to remove the root and a referral was inserted into the chart. Review of an oral surgical referral dated 09/12/24 revealed Resident #29 had residual root tips that needed to be removed. Review of the notes for Resident #29 dated 09/20/24 revealed she had an infection of the left lateral lower retained tooth post prior partial removal. Amoxicillin was ordered for ten days and administered. The resident was to follow-up with dentistry. Interview with Resident #29 on 06/03/25 at 11:31 A.M. revealed she had an appointment last year sometime to get a tooth pulled and was supposed to have another appointment to get the root pulled out and hasn't heard back from the staff about the appointment. She stated she uses oragel if needed if the tooth bothers her. She denied she was in pain with the tooth. Interview with the Appointment Scheduler	F 0791		

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F 0791	Continued From page 54 (AS) #200 on 06/09/25 at 9:44 A.M. revealed she called the surgical dentist clinic to schedule an appointment for the resident, but left a message because the recording says if they choose you to get your tooth fixed, they will call you and if not you won't hear back from the clinic. She reported the resident was on Medicaid and the surgery clinic was the only clinic that will take Medicaid residents. Review of the policy entitled "Dental Services" dated 04/02/24 revealed the facility will assist residents in obtaining routine and 24-hour emergency dental care/services to meet the needs of each resident.	F 0791		

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F 0804	Continued From page 55	F 0804		
F 0804 SS=E	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This STANDARD is not met as evidenced by: Based on observations, record review, staff interviews and facility policy review, the facility failed to prepared palatable food. This affected 29 residents, (#20, #39, #35, #5, #28, #2, #34, #12, #33, #198, #38, #8, #17, #27, #43, #29, #3, #13, #32, #198, #22, #10, #26, #31, #25, #24, #7, #23, and #37) who were served regular consistency textured diets. The facility census was 46. Findings Include: Review of medical records revealed the following residents had a physician order for a regular consistency textured diet, Resident #20, #39, #35, #5, #28, #2, #34, #12, #33, #198, #38, #8, #17, #27, #43, #29, #3, #13, #32, #198, #22, #10, #26, #31, #25, #24, #7, #23, and #37. Observation on 06/02/25 at 11:46 A.M. revealed Residents #11, #2, and #24	F 0804	F804 Urbana Health and Rehab wishes to point out to any person who reviews this document that we do not necessarily agree with the citations with which we were cited. However, the law requires us to prepare a plan of correction for the citations regardless of whether we agree with them or not. Thus, we have prepared such a plan as noted below. Please note though, that this plan does not constitute an admission that the citations are either legally or factually correct. This plan of correction is not meant to establish any standard of care, contract, obligation, or position and Urbana Health and Rehab reserves all rights to raise all possible contentions and defenses in any civil or criminal action or proceeding. Please accept 07/30/25 as the facility's allegation of compliance date. The facility failed to provide residents on a regular diet with palatable food affecting residents 20, 39,35,5,28,2,34,12,33,198,38,8,17,27,43,29,3 ,13,32,22,10,26,31,25,24,7,23, and 37. Step 1 Dietary Manager provided identified residents alternate menu items at their request. This was completed on 6/2/25 Step 2 Dietary Manager to audit current food supply to ensure we have ability to prepare the items properly for the best outcomes in taste and presentation. Audit completed to be by 6/30/25. Dietary manager will adjust weekly order to ensure menu items can be prepared by the kitchen appliances. Step 3 RRD to provide education on 6/18/25 to Dietary Manager to order alternative items when a specific way of preparation in unavailable at the facility. Step 4 To monitor and maintain ongoing compliance RRD/Designee will audit	07/30/2025

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F 0804	Continued From page 56 received popcorn shrimp at the lunch meal in the dining room. The shrimp had a white coating and was not browned. The residents appeared to have difficulty chewing the exterior coating. Observation on 06/02/25 at 12:06 P.M. Resident #29 received her lunch meal tray in her room. The plate contained popcorn shrimp. The shrimp had a white coating and appeared hard. Resident took bites of the shrimp and took it out of her mouth. Interview on 06/02/25 at 11:47 A. M. with Residents #11, #2 and #24 revealed the shrimp was unappetizing, difficult to chew and they could not eat the shrimp. Interview on 06/02/25 at 12:06 P.M. with Resident #29 revealed she could not chew or soften the shrimp coating to swallow it. Interview on 06/04/25 at 11:17 A.M. the Registered Dietitian #400 verified the shrimp served on 06/02/25 at lunch was not an oven ready product. It should have had a golden brown appearance and a coating that was easily chewed. Interview on 06/04/25 at 12:43 P.M. with Cook #250 it was verified on 06/02/25 she prepared the popcorn shrimp in the oven and stated the shrimp should have been prepared in a deep fryer. Cook #250 stated the facility did not have a deep fryer. Cook #250 verified the shrimp	F 0804	menu and preparation process weekly X4, then monthly x2 to ensure that menu items are being prepared properly with the equipment Urbana kitchen has available. Results of the audits will be forwarded to the facility QAPI committee for further review and recommendation	

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F 0804	Continued From page 57 remained white and the coating became harder in the oven. Review of facility policy, "Food Production and Safety ", dated 01/05/23 revealed foods are prepared by methods to maintain, develop and enhance flavor.	F 0804		

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F 0812	Continued From page 58	F 0812		
F 0812 SS=E	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This STANDARD is not met as evidenced by: Based on observations, staff interviews, record reviews, and facility policy review, the facility failed to prepare food in a sanitary manner. This affected 45 residents who received food from the kitchen. The facility census was 46. Findings Include: 1. Observation on 06/02/25 at 10:05 A.M.	F 0812	F812 Urbana Health and Rehab wishes to point out to any person who reviews this document that we do not necessarily agree with the citations with which we were cited. However, the law requires us to prepare a plan of correction for the citations regardless of whether we agree with them or not. Thus, we have prepared such a plan as noted below. Please note though, that this plan does not constitute an admission that the citations are either legally or factually correct. This plan of correction is not meant to establish any standard of care, contract, obligation, or position and Urbana Health and Rehab reserves all rights to raise all possible contentions and defenses in any civil or criminal action or proceeding. Please accept 7/30/25 as the facility's allegation of compliance date. The facility failed to prepare food in a sanitary manner affecting 45 residents that received food from the facility kitchen. Observation 1 DM did not have arm coverings on while preparing food and she has a diagnosis of psoriasis. Observation 2 Cook #250 failed to wear gloves nor did she sanitize her hands after touching her face when reassembling the food processor. Step 1 Regional Dietitian educated DM on dress and personal hygiene and instructed to don a jacket and/or arm coverings completed 6/4/25. Regional Dietitian educated Cook #250 on Handwashing in the Kitchen, Handling and Storage of Equipment and Utensils which included information on avoiding handling equipment that will come in contact with food and the drying of wet equipment, and Use of Disposable Gloves in the kitchen. Handwashing competencies	07/30/2025

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F 0812	Continued From page 59 of Diet Manger, (DM) #208 revealed white flakes of skin surrounded with bright reddened ring of skin on bilateral underside of forearms, measuring approximately four inches by two inches. When DM #208 touched the skin areas, flaky skin was removed. Interview on 06/02/25 at 10:05 A.M. with DM #208 verified the skin areas were diagnosed as a noncommunicable skin condition. DM #208 verified the skin areas should be covered due to the flaky skin. DM #208 verified her job duties include food preparation, food service and dishwashing/sanitizing. Observation on 06/04/25 at 11:17 A.M. of DM #208 revealed the skin areas on her bilateral forearms were exposed with no protective covering and the staff was observed at the three compartment sink washing/sanitizing dishes. DM #208 was also observed to assist with the preparation of puree food items. Interview on 06/04/25 at 11:17 A.M. with DM #208 verified she did not have protective covering on her exposed skin areas on the bilateral forearms. She stated the kitchen was hot, but she would don a jacket to cover the skin areas. Observation on 06/04/25 at 11:39 A.M. revealed DM #208 had donned a jacket with long sleeves. DM #208 was observed to wash/sanitize dishes in the three compartment sink, however the	F 0812	completed 6/2/25 by Regional Dietitian. Step 2 The potential to affect all residents. Cognitive residents interviewed for adverse effects in last 30 days, non-verbal or cognitive impaired residents had medical records review with look back of 30 days, to be completed by 7/15/25. Step 3 All dietary staff to be educated by the RRD/designee on Facility policies "Food and Nutrition, Personnel and Training" and Food and Nutrition, Sanitation and Infection Control" by 6/30/25. Step 4 To monitor and maintain ongoing compliance RRD/designee will audit 1 dish washing process daily weekly X4, then monthly x2 to ensure proper sanitation and infection control practices are being adhered to. Results of the audits will be forwarded to the facility QAPI committee for further review and recommendation	

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F 0812	Continued From page 60 sleeves of the jacket were pushed up and the skin areas remained exposed. Interview on 06/04/25 at 11:39 A.M. with DM #208 verified the sleeves of the jacket were pushed up and the skin areas remained exposed while she used the three compartment sink to wash/sanitize the dishes. Review of facility policy, "Food and Nutrition, Personnel and Training", dated 03/28/25 revealed food employees report to work in clean/safe attire. Ohio Administrative Code 3717-1 -01 A, states food employees are to keep their hands and exposed portions of their arms clean. Workers with psoriasis should consider wearing protective coverings when handling food minimize the risk of skin flakes contaminating food. 2. Observation on 06/04/25 at 11:17 A.M., revealed Cook #250 was preparing the pureed foods with a food processor. Cook #250 was noted to rub her forehead with her bare hand and arm, partially exposing her hair from under the hairnet during the puree process. Between pureeing the meat mixture and then pureeing the tomatoes, Cook #250 washed the blender bowl in the three compartment sink. Cook #250 immediately reassembled the food processor by placing the bowl blade into the bowl with her bare hands. The bowl was observed to contain rinse water from the three compartment sink which covered the bottom of the bowl.	F 0812		

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F 0812	Continued From page 61 Interview on 06/04/25 at 12:02 P.M. Cook #250 verified she reassemble the blender bowl blade in the bowl with her bare hands and did not ensure the water was removed from the bowl prior to processing the next food item. Cook #250 verified she rubbed her head with her bare hand and did not then sanitize her hands. Cook # 250 also confirmed when she used her bare hand to rub her face it dislodged hair from her hair net. Review of facility policy, "Food and Nutrition, Sanitation and Infection Control", dated 06/01/18 revealed when handling cleaned and sanitized equipment, staff will avoid touching the parts that will come in contact with the food. Review of facility policy, "Food and Nutrition, Personnel and Training", dated 03/28/25 revealed food employees wear a hair restraint which will cover all hair.	F 0812		

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F 0880	Continued From page 62	F 0880		
F 0880 SS=E	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents	F 0880	F880 The facility failed to ensure proper infection control measures when A) the RN #204 dropped medication for resident #15 on the medication cart during medication administration, then placed medication in medication cup and B) when the Dietary Manager #208 assisted with passing meal trays on the B-front hall without performing proper hand hygiene during tray pass for residents #98, #5 and #99. Step 1: The facility DON immediately educated A) the RN #204 on proper maintenance of infection control practices during medication administration and B) the Dietary Manager #208 on proper hand hygiene practices while passing meal trays. Hand Hygiene competencies were completed on both individuals as well. Completed on 6/10/25 Step 2: This has the potential to affect residents #15, #98, #5, #99; The DON will assess the identified residents #5 and # 15 for potential effects on 7/10/25. Unable to assess #98 and #99 as these residents are not identified on the resident identifier list provided by the ODH Surveyors. Step 3: To prevent this from recurring the DON or designee will educate A) licensed nurses on proper infection control principles during medication administration and B) staff that assist with meals on proper hand hygiene during meal process. Completed on 7/11/25 Step 4: To monitor and maintain ongoing compliance the DON or designee will audit A) maintenance of proper infection control practices during medication administration 2x per week x4 weeks then 2x per month x2 months and B) use of proper hand hygiene during tray pass 3x per week x4 weeks then monthly x2 months. Audits will begin 7/14/25	07/30/2025

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F 0880	Continued From page 63 of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 0880	The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.	

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F 0880	Continued From page 64 This STANDARD is not met as evidenced by: Based on observation, medical record review, staff interview, and facility policy review the facility failed to ensure facility staff performed hand hygiene. This affected one resident (#15) observed during medication pass and additionally affected three residents (#98, #5, and #99) who had their meal trays delivered by staff without hand hygiene being performed. The census was 46. Findings included: 1. Review of Resident #15's medical record revealed an admission date 08/21/24. Diagnoses included chronic diastolic heart failure, depression, vascular dementia, paroxysmal atrial fibrillation, and hypertension. Review of the quarterly Minimum Data Set (MDS) dated 04/25/25 revealed the resident scored a one on the Brief Interview of Mental Status indicating the resident had severe cognitive impairment. Review of physician orders revealed the resident had the following medication orders: Lasix (diuretic) 40 milligrams (mg) take one tablet twice a day dated 08/21/24, Senna plus (laxative) 8.6-50 mg take two tablets twice a day dated 08/24/24, and Eliquis (anticoagulant) 5 mg one tablet take twice a day dated 01/09/25. Observation of medication pass for	F 0880		

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F 0880	Continued From page 65 Resident #15 on 06/04/25 at 8:00 A.M. with Registered Nurse (RN) #204 revealed as the medications were prepared RN # 204 dropped the Lasix, Eliquis and the Senna plus on the top of the medication cart, and used her bare, ungloved hand to pick up the medication and put the medication in the medication cup with the rest of the morning medication for Resident #15. RN #204 proceeded to crush all of Resident #15's medications, place them in applesauce and administer the medications to the resident. Interview on 06/04/25 at 8:15 A.M. with RN #204 it was verified she had dropped the Lasix 40 mg, Eliquis 5 mg, and Senna plus 8.6-50 mg on top of her medication cart that was not clean and used her bare, ungloved fingers to pick up the medications and put the medication in the cup, crushed the medication and administered the medications to Resident #15. 2. Observation on 06/04/25 at 12:29 P.M. Dietary Manger, (DM) #208 was observed to pass lunch meal trays to three residents in three separate residents (#98, #5, and #99). DM #208 did not perform hand hygiene between resident tray passes. DM #208 was observed to enter each room, remove the food lid on the tray, set the lid down in the room, touching items on the tray and the food delivery cart. DM #208 then exited the individual resident room walking past a	F 0880		

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F 0880	Continued From page 66 hand sanitizer dispenser which is mounted on the wall in each resident room. DM #208 was observed to pass the three trays to Resident #98, #5, and #99 without performing hand hygiene. Interview on 06/04/25 at 12:29 P.M. DM #208 verified she did not wash her hands or use hand sanitizer between each resident meal tray delivery. She stated she knew better and should have used hand sanitizer between each meal tray delivery. She stated she did not often deliver trays to the residents. Review of facility policy, "Hand Hygiene", dated 02/28/25 revealed employees are to use alcohol based rub or hand wash after touching a patient's environment	F 0880		

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F 0921	Continued From page 67	F 0921		
F 0921 SS=E	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This STANDARD is not met as evidenced by: Based on observation, medical record review, staff interview, resident interview, resident council minutes review, maintenance work order review, and policy review, the faciity failed to provide an homelike environment. This affected nine residents (#3, #7, #8, #14, #29, #37, #38, #39, and #198) directly and affected all 26 residents on the A Unit of 46 resident rooms observed for environment. The facility census was 46. Findings included: 1. Review of record for Resident #38 revealed she was admitted on 07/12/22. Diagnoses included hypertension, acute respiratory failure, chronic obstructive pulmonary disease, and oxygen dependent. Review of Quarterly Minimum Data Set (MDS) assessment dated 02/01/25 revealed Resident #38 was alert and oriented. Review of the facility document work order date 05/01/25 revealed that Resident #38 had an order to fix her	F 0921	F921 The facility failed to maintain a homelike environment for residents #3, #7, #8, #14, #29, #37, #38, #39, #198 directly and all 26 residents on A Wing when A) 2 PTAC room units (HVAC) stopped working appropriately in residents #198 and #38 rooms B) Resident #29 toilet dirty, sink rusted and floors dirty/sticky C) Resident #39 bed remote needing replaced, the floor was sticky, the light above the sink needed replaced and the light cover was yellowed, toilet caulking around toilet stained D) Resident #8 sink rusted, light over sink yellowed, bathroom floor tiles stained, metal hinges on toilet seat dirty, gouges in bathroom doorway paint E) Resident #3 floors with buildup in corners, gouges in drywall, tape on call light, bathroom floor with stains, toilet with yellowish stains, furniture in disrepair, unable to use over-the-bed light due to length of string, dust on lights/bulbs F) Resident #37 toilet with yellowish stains and sticky floor G) A Wing Shower Room 69 degree ambient temperature with non-functioning heater and fan louvers with build-up H) All resident rooms on A Wing with buildup of blackened material at threshold to hallway I) Resident #14 missing/damaged wallpaper near bed J) One chair in main Dining Room with damaged arm rest, remaining chairs with protective finish removed due to wear and in overall disrepair. Step 1: The facility immediately A) replaced the PTAC units in the rooms of both resident #198 and #38, in addition to placing order with contracted maintenance company BIS to assess, secure parts, and/or order additional units Completed 6/5/25. B) The Maintenance Director audited resident rooms/bathrooms to	07/30/2025

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F 0921	Continued From page 68 broken air conditioner. Interview on 06/03/25 at 3:05 P.M., with Resident #38 who stated that her room air conditioner had been out for a month. Resident #38 stated Maintenance Director (MD)#202 had informed her that he would order parts to be fixed. Resident #38 stated she has not seen MD #202 since. Resident #38 stated she was on oxygen and liked it cooler in her room. Observation on 06/03/25 at 3:05 P.M. room was warm, with a fan blowing on her to cool her. Resident #38 skin was warm to touch. Interview on 06/04/25 at 3:45 P.M., MD #202 verified that Resident #38 had not had her air conditioner fixed for two months, because there was an old air conditioner unit in Resident #38 room. Maintenance #202 stated he did not find any parts to be replaced for the old unit. 2. Review of record for Resident #198 revealed she was admitted on 09/22/22. Diagnoses included acute and chronic systolic and diastolic heart failure, hypertension, and chronic obstructive respiratory failure with hypoxia. Review of Quarter MDS dated 12/13/24 revealed that Resident #198 was alert and oriented. Review of the facility document work order date 05/01/25 revealed that Resident #198 had an order to fix her broken air conditioner.	F 0921	identify a priority schedule for installation of new flooring, replacement of lighting units, toilet and sinks Completed on 7/10/25 . C) The toilets in question were immediately cleaned Completed on 6/10/25. D) DOM will create schedule for installation of new flooring into non-priority rooms/areas as well as replacement of lighting unit, sinks and toilets Completed on 7/10/25. The Maintenance Director has initiated repairs to identified areas noted above including the following measures: B) Resident #29 toilet dirty cleaned 6/10/25, sink rusted plan to replace and floors dirty/sticky cleaned 6/10/25 C) Resident #39 bed remote needing replaced completed 6/10/25, the floor was sticky and cleaned 6/10/25, the light above the sink needed replaced and the light cover was yellowed both replaced 6/10/25, toilet caulking around toilet stained plan to replace D) Resident #8 sink rusted plan to replace, light over sink yellowed replaced 6/10/25, bathroom floor tiles stained plan for new flooring, metal hinges on toilet seat dirty cleaned 6/10/25, gouges in bathroom doorway paint, plan to repaint E) Resident #3 floors with buildup in corners cleaned 6/10/25, gouges in drywall repaired 6/4/25, tape on call light removed 7/10/25 , bathroom floor with stains plan to replace, toilet with yellowish stains plan to replace, furniture in disrepair plan to replace, unable to use over-the-bed light due to length of string replaced 7/10/25, dust on lights/bulbs cleaned/dusted 7/10/25 F) Resident #37 toilet with yellowish stains plan to replace and sticky floor cleaned 6/10/25 G) A Wing Shower Room 69 degree ambient temperature with non-functioning heater and fan louvers with	

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F 0921	Continued From page 69 Observation on 06/03/25 at 3:50 P.M., with Resident #198 who was sitting in her recliner. Resident #198's room was warm. Resident #198 was sitting watching television with a box fan blowing on her while on 4 liters of oxygen. Resident #198 was flushed and sweaty. Interview on 06/03/25 at 3:55 P.M., with MD #202 verified that Resident #198 also had no air conditioner in her room. Maintenance #202 stated the parts were unable to be found to repair the unit. 3. Observation of Resident #29's room on 06/03/25 at 11:26 A.M., revealed the toilet was dirty and had a metal piece on the back of the toilet to hold the seat in place that had built up yellowish gray substance on it. The handwashing sink was rusted, there was tape holding the light cover in place behind her bed, the floor was dirty and sticky and the corners of the floor had a build up gray substance in the corners. Interview with Resident #29 on 06/03/25 at 11:28 A.M., revealed she didn't like her floors looking the way they do and didn't like her toilet and sink with the rust and thought they were dirty. 4. Observation of Resident #39's room on 06/03/25 at 12:26 P.M., revealed the wires to her bed control were disconnected and the resident wasn't able to control the bed movement, the floor was sticky, the light above the	F 0921	build-up corrected 6/4/25 H) All resident rooms on A Wing with buildup of blackened material at threshold to hallway, adhesive from new/replaced hallway flooring removed 7/10/25 I) Resident #14 missing/damaged wallpaper near bed plan to remove paper and paint room J) One chair in main Dining Room with damaged arm rest removed from use, remaining chairs with protective finish removed due to wear and in overall disrepair, plan to replace all Dining Room chairs. Step 2: This has the potential to affect all residents. The DOM or designee will create a Master Deep Cleaning schedule for all resident rooms/bathrooms/shower rooms. The LNHA will place a request for capital funds to replace sinks, toilets, and furniture identified as in disrepair. Will be completed on 7/10/25 Step 3: To prevent this from recurring the LNHA, DOM or designee will educate staff on the work order process. The DOM will educate the environmental services staff on the Master deep cleaning schedule. The DON will educate STNA's on need for cleaning toilets and floors throughout the day and night when soiled. Completed on 7/11/25 Step 4: To monitor and maintain ongoing compliance the LNHA or designee will audit 5 rooms for repair/maintenance needs 5 times per week and complete work order notifications. DON will audit 8 toilets weekly x4 weeks then monthly times 2 months. DOM will audit 6 HVAC vents weekly x4 weeks then monthly x2 months. Audits to begin on 7/14/25 The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.	

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F 0921	Continued From page 70 Handwashing sink was burned out and the light cover was a dark yellow. Around the toilet and the floor in the bathroom was a dark gray substance and the caulking around the toilet was supposed to be white but it turned to a dark grayish color. 5. Observation of Resident #8's room on 06/03/25 at 3:14 P.M., revealed the sink was rusted, the light over the sink was yellowed to the point the light didn't get bright, there were gray stains on the bathroom floor tile, back of the toilet had a metal piece holding the toilet seat to the toilet revealed it had gray substance on it, and there were gouges on the doorway coming out of the bathroom. 6. Observation of Resident #3's room on 06/03/25 at 2:05 P.M., revealed the corners on the floor had a built up gray substance in them, there were gouges out of the walls next to her bed, the call light was taped at the connector, the bathroom floor had gray stains on it and around the bottom of the toilet was yellowed, furniture had gouges out of it and scraps on the dresser, she wasn't able to turn on her light from the bed because the string was too short, there is built up dirt on the lights and dusty bulbs. 7. Observation of Resident #37's room on 06/03/25 at 2:57 P.M., revealed the toilet seat and around the bottom of the toilet was yellowed. The floor was sticky.	F 0921		

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F 0921	Continued From page 71 Observation and interview on 06/05/25 from 8:28 A.M. to 8:41 A.M., with the Maintenance Director (MD) #202, confirmed all of the above mentioned areas were in need of repair. He revealed he had no help and did the best he could. 8. Review of Resident Council Meeting dated 01/28/25 and 03/19/25 revealed the residents reported low temperatures in the shower rooms. Resident Council Meeting minutes dated 02/11/25 and 03/19/25 revealed residents reported the A unit shower room was cold. Observation on 06/09/25 at 9:06 A.M. with Maintenance Director (MD) #202 revealed the room temperature near the entrance door to the shower room was 69 degrees Fahrenheit. The ceiling exhaust fan was on and there was a draft from under the door, across the shower area to the exhaust fan. There were four ceiling intake fans and louvers with a heavy build up of gray debris resembling dust and dirt above the resident shower and dressing areas. When turning on the switch to the wall heater, the unit did not come on. Interview on 06/09/25 at 9:06 A.M., MD #202 verified the shower room temperature should be 71 to 81 degrees Fahrenheit, and /or what residents feel is comfortable. He stated the fans and louvers needed cleaned and verified the wall heater did not work. He verified a draft from the floor to the ceiling in the	F 0921		

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F 0921	Continued From page 72 shower area. He verified the residents had reported the A unit shower room was cold. 9. Review of the Resident Council Meeting minutes dated 05/13/25 revealed residents reported the rooms were not getting cleaned. Observation of A unit door entry floors to all resident rooms, (Rooms #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25 and #26) had a blacked build up at the threshold strip juncture with the hallway. There was a blackened buildup at the doorway and corners in the rooms. Interview on 06/05/25 at 7:30 A.M., the MD #202 verified the blacked area at every room on the A unit floor at the entry way and in rooms corners. The MD #202 stated the A unit had not been renovated and there was no written planned program for the completion of the floor replacement or cleaning. 10. Record review of Resident #14 revealed the resident was admitted to the facility on 05/18/20. Diagnoses for Resident #14 include dementia, anxiety disorder, dysphagia, repeated falls, malnutrition, anemia, muscle weakness, and osteoporosis. Review of the Minimum Data Set, (MDS) comprehensive assessment dated 05/15/25 revealed the resident had	F 0921		

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F 0921	Continued From page 73 severely impaired cognition and was dependent on staff for all Activities of Daily Living skills. Observation on 06/02/25 at 9:50 A.M., revealed Resident #14's bed up against the wall on the right side. There was a strip of wallpaper approximately 45 inches wide and six feet long missing from the wall, exposing a rough surface. Interview on 06/05/25 at 7:30 A.M., the MD # 202 verified Resident #14 had missing wallpaper with a rough surface. He verified Resident #14 laid up near the wall. MD #202 stated he was not notified of the missing wallpaper. 11. Record review of Resident #37 revealed the resident was admitted to the facility on 06/28/21. Diagnosis for Resident # 37 included dementia, insomnia, and cognitive communication deficit. The resident wore a monitor device for elopement monitoring. Review of the Minimum Data Set, (MDS) comprehensive assessment dated 3/31/25 revealed the resident had severely impaired cognition and ambulated without assistance devices. Review of the Resident Council Meeting minutes dated 03/11/25 revealed residents reported the chairs needed repaired. Observation on 06/03/25 at 11:12 A.M., of the dining room chairs revealed one chair	F 0921		

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F 0921	Continued From page 74 of ten in the main dining room, had the left arm not adhered to the chair. The arm of the chair could easily be removed from the connecting joint when pulled up. Ten of the ten chairs had worn wooded arms with the water sealing finished removed, leaving a penetrable surface in the wood grain. Interview on 06/02/25 of Certified Nursing Assistant (CNA) #206 verified the dining chair was broken and set it along the wall in the dining room. He verified the wooden arms of all the dining chairs were worn and had the protective surfaces removed. Observation on 06/04/25 at 10:002 A.M., the identified dining room chair remained in use in the dining room by Resident #37. Interview on 06/05/25 at 7:30 A.M., the MD #202 verified the identified dining room chair remaining in the dining room and the arm of the chair was broken. MD #202 verified a resident sitting in the chair could easily pull the arm up and the chair be destabilized. MD #202 verified all the dining room chairs had exposed wooden penetrable surfaces on the chair arms. MD #202 stated the broken chair was not reported to him and taken out of service. He stated setting the chair aside in the dining room was not putting the chair out of service. Review of facility policy, "Routine Environmental Cleaning", dated 06/28/24,	F 0921		

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F 0921	Continued From page 75 revealed proper cleaning of environmental surfaces is necessary to break the chain of infection. This deficiency represents non-compliance investigated under Complaint Numbers OH00163527 and OH00162529.	F 0921		

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F 0925	Continued From page 76	F 0925		
F 0925 SS=D	483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This STANDARD is not met as evidenced by: Based on observation and resident interview, family member interview, and staff interview, the facility failed to ensure a resident was provided a pest free environment. This affected one (#11) of 46 resident rooms observed for pest. The facility census was 46. Findings include: Record review of Resident #11 revealed the resident was admitted to the facility on 04/22/25. Diagnosis for Resident #11 include cerebral infarction, muscle weakness, dysphagia, and anxiety. Review of the Minimum Data Set (MDS) comprehensive assessment dated 04/29/25 revealed the resident had intact cognition and was dependent on staff for dressing and transfers. Observation on 06/02/25 at 10:05 A.M., revealed the Resident #11 in room B 23. On 06/03/25, Resident #11 was moved into room B 21. Observation on 06/03/25 at 8:30 A.M. revealed 10 to 20 quarter length black insects with wings on the floor in Resident #11 previous room, room B23. There were no insects observed in the B 23	F 0925	F925 The facility failed to maintain an effective pest control program when insects where observed in room B23 requiring that resident #11 be moved to another room on 6/2/25 at which time pest control was contacted. As of 6/5/25 pest control still had not arrived to exterminate. Step 1: The facility SSD and DOM immediately moved resident #11 from room B23 to room B21on 6/2/25. The DOM called pest control initially on 6/1/25 and again on 6/9/25. The facility DOM checked all other rooms on 6/2/25 with no negative findings. Resident #11 was assessed by facility LPN on 6/1/25 and 6/3/25 with no negative effects. Step 2: This has the potential to effect all residents. Pest control reports they are scheduled to treat facility on 7/2/25. Completed on 7/3/25. Step 3: To prevent this from reoccurring the LNHA will educate current staff on reporting any pest control needs when observed. Completed on 7/11/25 Step 4: To maintain ongoing monitoring and compliance the LNHA or designee will audit 5 random resident rooms for signs of pests weekly x 4 weeks then monthly x2 months. Audits begin 7/14/25 The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.	07/30/2025

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F 0925	Continued From page 77 room on 06/02/25. Interview on 06/03/25 at 8:30 A.M., Resident #11 revealed she had a "swarm of flying ants" coming out of the ceiling near her window six feet from her bed, in the past day. She stated she was afraid the ants would get in her mouth when she slept. Interview on 06/03/25 at 8:35 A.M. , with Certified Nursing Assistant, (CNA) #22 verified the winged insects on the floor in B 23 and verified Resident #11 had been moved on 06/02/25 evening shift due to the flying insects. Interview on 06/04/25 at 7:10 A.M., with Resident #11 family representative stated when she visited a week ago, she had seen her mother with the bugs on her. She had to remove the insects off of Resident #11. Resident #11 family representative stated the resident had weakness to one side, and was unable to get them off herself. Resident #11 family representative stated she was upset because the facility did not manage pests in her mother's room. Interview on 06/05/25 at 7:30 A.M., with the Maintenance Director (MD) #202 verified Resident #11 had flying insects in her room on 06/02/25 and was moved due to the resident's request. He stated he was aware of the insects on 06/02/25 and contacted the pest control, which had not arrived to exterminate as of	F 0925		

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F 0925	Continued From page 78 06/05/025.	F 0925		