| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (x2) multiple construction | (X3) DATE SURVEY COMPLETED |
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| | 366143 | a. building _____ b. wing _____ | 03/26/2026 |

| name of provider or supplier | street address, city, state, zip code |
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| ADAMS COUNTY MANOR | 10856 STATE ROUTE 41 WEST UNION OH, 45693 |

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| F 0000 | INITIAL COMMENTS<br><br>ANNUAL SURVEY<br><br>COMPLAINT INVESTIGATION<br><br>MASTER COMPLAINT NUMBER 2677468 AND COMPLAINT NUMBER 2647177<br><br>ADMINISTRATOR: Michael Hanson #7551<br><br>CERTIFIED BED CAPACITY: 74<br><br>CENSUS IN HOUSE: 69<br><br>The following deficiencies are based on the annual and complaint survey completed 03/26/26. | F 0000 | | |

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

MICHAEL.HANSON | 04/20/2026

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 0584 | Continued From page 1 | F 0584 | | |
| F 0584 SS=E | 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment<br>§483.10(i) Safe Environment.<br><br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br><br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br><br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br><br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; | F 0584 | DON completed a head-to-toe physical assessment/observation on Resident #10, #11, #35, & #38 on 04/06/2026. It was determined that there were no negative effects related to the shower tiles not being in good repair identified during Annual Survey. LNHA notified Resident #10, #11, #35, & #38's primary care provider on 03/26/2026, of findings noted during Annual Survey and that no negative effects were identified during head-to-toe assessment/observation. Primary care provider acknowledged that the resident's shower floor was not in good repair (broken uneven tile) and that there were no negative effects related to the shower floors' lack of good repair. No new orders received from primary care provider. Maintenance Director replaced shower floor tiles in room #106 on 04/17/2026. Maintenance Director will replace shower floor tiles in room #203 (resident # 11 & #12) & 206 (resident #35 & 38) on or before 04/24/2026. On or before 04/30/2026, LNHA/Designee will observe shower rooms' flooring in the rooms of like residents (all shower floors in facility) to ensure that tile is in good repair. Any tile identified flooring that is not in good repair will be repaired/replaced also on or before 04/30/2026. On or before 04/30/2026, LNHA/Designee will educate Maintenance Director as follows: 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, | 04/30/2026 |

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| F 0584 | Continued From page 2<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br><br>This STANDARD is not met as evidenced by:<br><br>Based on observation, resident interview, staff interview, and review of facility policy, the facility failed to ensure resident shower floors were maintained in good repair. This affected four (Residents #10, #11, #35, and #38) of the 24 residents sampled for showers. The facility census | F 0584 | comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. On or before 04/30/2026, LNHA/Designee will review room monitoring procedures and expectations with the interdisciplinary team (IDT). This review will observe what tasks/reviews/observations are being completed during weekly room rounds. LNHA/Designee will ensure that shower room flooring observation is specifically listed on the weekly room rounds. Additionally, when a floor is found to not be in good repair, a Maintenance Request will be submitted for Maintenance to observe/address the issue noted. Such requests will be monitored electronically by the LNHA/Designee ongoing. LNHA/Designee | |

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| F 0584 | Continued From page 3<br>was 69 residents<br><br>Findings include:<br><br>Observation on 03/23/26 at 1:16 P.M. revealed the shower floor in Resident #10 and Resident #11's bathroom had a large amount of water pooled on top of the tiles. Several floor tiles were cracked, grout was missing between multiple tiles, and the surface of the tiles was uneven.<br><br>Observation on 03/26/26 at 9:00 A.M. revealed the shower floor in the room of Resident #35 and Resident #38's bathroom had multiple broken and/or missing tiles, and the surface of the tiles was uneven.<br><br>Interview on 03/26/26 at 9:01 A.M with Resident #35 confirmed multiple tiles on the shower floor were missing or broken and the water did not drain well.<br><br>Interview on 03/26/26 at 9:10 A.M with Certified Nursing Assistant (CNA) #562 confirmed the shower floors in Resident #10, #11, #35, and #38's bathrooms had | F 0584 | will complete audits. The audit will observe 5 shower floors every week x4 weeks; then as determined by QAA, to determine if the floors are in good repair. Any floors observed to not be in good repair will be repaired/replaced. | |

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| F 0584 | Continued From page 4<br>missing, cracked, and broken tiles and confirmed the water did not drain correctly from the showers causing water to pool on the shower floors after the residents' showers.<br><br>Review of the facility policy titled Homelike Environment undated revealed the facility encouraged the personalization and comfort of a home-like environment.<br><br>This deficiency represents noncompliance investigated under Complaint Number 2647177. | F 0584 | | |

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| F 0605 | Continued From page 5 | F 0605 | | |
| F 0605 SS=D | 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) Right to be Free from Chemical Restraints<br>§483.10(e) Respect and Dignity.<br><br>The resident has a right to be treated with respect and dignity, including:<br><br>§483.10(e)(1) The right to be free from any . . . chemical restraints<br><br>imposed for purposes of discipline or convenience, and not required to treat the<br><br>resident's medical symptoms, consistent with §483.12(a)(2).<br><br>§483.12<br><br>The resident has the right to be free from abuse, neglect, misappropriation of<br><br>resident property, and exploitation as defined in this subpart. This includes but is<br><br>not limited to freedom from corporal punishment, involuntary seclusion and any<br><br>physical or chemical restraint not required to treat the resident's medical<br><br>symptoms. | F 0605 | DON completed a head-to-toe physical assessment/observation on Resident #6 on 03/26/2026. It was determined that there were no negative effects related to the lack of behavioral monitoring identified during Annual Survey. LNHA notified Resident #6's primary care provider on 03/26/2026, of findings noted during Annual Survey and that no negative effects were identified during head-to-toe assessment/observation. Primary care provider acknowledged the missing behavioral documentation and that there were no negative effects related to the lack of behavioral monitoring. No new orders received from primary care provider. DON completed a head-to-toe physical assessment/observation on Resident #20 on 03/26/2026. It was determined that there were no negative effects related to the lack of behavioral monitoring identified during Annual Survey. LNHA notified Resident #20's primary care provider on 03/26/2026 of findings noted during Annual Survey and that no negative effects were identified during head-to-toe assessment/observation. Primary care provider acknowledged the missing targeted behavioral documentation and that there were no negative effects related to the lack of behavioral monitoring. No new orders received from primary care provider. On or before 04/30/2026, DON/Designee will review other residents' diagnosis list. Any resident with a mental health diagnosis, will have a medication review completed to ensure that targeted behavioral observations are added to treatment administration record (TAR) so that nurses will review/document any specific experienced behaviors on their shift | 04/30/2026 |

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| F 0605 | Continued From page 6<br><br>§483.12(a) The facility must-. . .<br><br>§483.12(a)(2) Ensure that the resident is free from . . . chemical restraints<br><br>imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms.<br><br>. . . .<br><br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br><br>(i) Anti-psychotic;<br><br>(ii) Anti-depressant;<br><br>(iii) Anti-anxiety; and<br><br>(iv) Hypnotic.<br><br>§483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-<br><br>(1) In excessive dose (including duplicate drug therapy); or<br><br>(2) For excessive duration; or | F 0605 | accordingly. On or before 04/30/2026, DON/Designee will educate licensed nursing personnel of the following: 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) Right to be Free from Chemical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 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)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without | |

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| F 0605 | Continued From page 7<br><br>(3) Without adequate monitoring; or<br><br>(4) Without adequate indications for its use; or<br><br>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br><br>§483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--<br><br>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; | F 0605 | adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Additionally, licensed nursing personnel will be educated on policy review / adjustment as | |

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| F 0605 | Continued From page 8<br><br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br><br>This STANDARD is not met as evidenced by:<br><br>Based on medical record review and staff interview, the facility failed to ensure appropriate monitoring of target behaviors for residents receiving antipsychotic medications. This affected two (Residents #6 and #20) of five residents | F 0605 | well as expectations for monitoring targeted behavior as noted in the following paragraph: On or before 04/30/2026, LNHA/Designee will review facility's policy & procedure regarding targeted behavioral monitoring. During this review, IDT will ensure that all residents with mental health, intellectual diagnoses or who are taking antipsychotic medications have specific targeted behavioral monitoring tasks placed/implemented, so that licensed nursing personnel are documenting behaviors or lack of behaviors that occur during their shift. This will include every shift documentation by licensed nursing personnel. DON/Designee will complete an audit of 5 residents' medical records weekly x4; then as determined by QAA. This audit will include the patient's identifier (facility's patient identifier), any behaviors were indicated and documented (will also reflect if no behaviors occurred), interventions to any behaviors that were documented. New procedure will include behavioral monitoring for those who suffer from mental health/intellectual disabilities and also those who do not. | |

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| F 0605 | Continued From page 9<br>reviewed for unnecessary medications. The facility census was 69 residents.<br><br>Findings include:<br><br>1.Review of the medical record for Resident #6 revealed an admission date of 04/17/23 with diagnoses including acute kidney failure, psychotic disorder, anxiety disorder, and bipolar disorder.<br><br>Review of the physician's order for Resident #6 revealed an order dated 11/19/25 for Abilify (an antipsychotic medication) 10 milligrams (mg) by mouth once a day at bedtime related to psychotic disorder with hallucinations.<br><br>Review of the Minimum Data Set (MDS) assessment for Resident #6 dated 12/16/25, revealed the resident was cognitively intact and received antipsychotic medication.<br><br>Review of the medical record for Resident #6 revealed it did not include target behaviors and/or monitoring of behaviors related to the administration of Abilify. | F 0605 | | |

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| F 0605 | Continued From page 10<br><br>Interview on 03/26/26 at 12:10 P.M with Assistant Director of Nursing #490 confirmed facility staff had not identified or monitored target behaviors related to the administration of Abilify for Resident #6.<br><br>2. Review of the medical record for Resident #20 revealed an admission date of 12/17/24 with diagnoses including Wernicke's encephalopathy, alcohol abuse, psychotic disorder with hallucinations, and dementia.<br><br>Review of the MDS assessment for Resident #20 dated 12/22/25 revealed the resident was was cognitively intact and received antipsychotic medication.<br><br>Review of the physician’s order for Resident #20 revealed an order dated 02/12/26 for Zyprexa (an antipsychotic medication 7.5 mg by mouth once a day at bedtime related to Wernicke's encephalopathy.<br><br>Review of the medical record for Resident #20 revealed it did not include target | F 0605 | | |

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| F 0605 | Continued From page 11<br>behaviors and/or monitoring of behaviors related to the administration of Zyprexa.<br><br>Interview on 03/24/26 at 1:50 P.M. with the Director of Nursing confirmed facility staff had not identified or monitored target behaviors related to the administration of Zyprexa for Resident #20. | F 0605 | | |

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| F 0641 | Continued From page 12 | F 0641 | | |
| F 0641 SS=D | 483.20(g)(h)(i)(j) Accuracy of Assessments<br>§483.20(g) Accuracy of Assessments.<br><br>The assessment must accurately reflect the resident's status.<br><br>§483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>§483.20(i) Certification.<br><br>§483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.<br><br>§483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>§483.20(j) Penalty for Falsification.<br><br>§483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-<br><br>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than | F 0641 | DON completed a head-to-toe physical assessment/observation on Resident #11 on 03/26/2026. It was determined that there were no negative effects related to the lack of "Side Rail Assessment"/Grab Bar Evaluation. DON completed an assessment for the need and use of bilateral handrails to promote bed mobility due to weakness on 03/26/2026. It was determined that the bedrail is being used for promoting bed mobility not being used in a way that prevents or restrains Resident #11 from normal daily functioning. LNHA notified Resident #11's primary care provider on 03/26/2026, of findings noted during Annual Survey and that no negative effects were identified during assessment/observation related to the lack of "Side Rail Assessment"/Grab Bar Evaluation documentation. MDS Nurse corrected Resident #11's MDS on 03/20/2026 to reflect that his bed rails were no longer being used. On or before 4/30/2026, DON/Designee will ensure that other residents residing in the facility and using bedrails have a "Side Rail Assessment"/Grab Bar Evaluation completed to verify that bedrails are being utilized to promote mobility and in no way prevent/restrain a person from their normal daily function(ing). Assessment/evaluation by nursing/therapy will establish the use of which side or bilateral grab bars for mobility purposes. All residents will have care plan in place reflecting the accurate use of grab bar for mobility purposes. DON completed a head-to-toe physical assessment/observation on Resident #20 on 03/26/2026. It was determined that there were no negative effects related to the lack of documentation or | 04/30/2026 |

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| ADAMS COUNTY MANOR | 10856 STATE ROUTE 41 WEST UNION OH, 45693 |

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| F 0641 | Continued From page 13<br>$1,000 for each assessment; or<br><br>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.<br><br>§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.<br><br>This STANDARD is not met as evidenced by:<br><br>Based on medical record review, observation, and staff interview, the facility failed to ensure Minimum Data Set (MDS) assessments were coded to accurately reflect immunizations and restraint use. This affected two (Residents #11 and #20) of 24 sampled residents. The facility census was 69 residents.<br><br>Findings include:<br><br>1.Review of the medical record for Resident #11 revealed an admission date of 02/14/25 and with diagnoses including dementia, mood disorder, and anxiety disorder.<br><br>Review of the physician’s orders for | F 0641 | related to the documentation discrepancy regarding the Pneumococcal vaccination (nursing documentation reflects that the vaccine was refused, but the MDS documentation describes that it was not offered) identified during Annual Survey. LNHA notified Resident #20's primary care provider on 03/36/2026, of findings noted during Annual Survey and that no negative effects were identified during assessment/observation related to the documentation discrepancy regarding the Pneumococcal vaccination (nursing documentation reflects that the vaccine was refused, but the MDS documentation describes that it was not offered). Primary care provider acknowledged the documentation discrepancy pertaining to the Pneumococcal vaccination. No new orders were provided. On or before 4/30/2026, DON/Designee will review the medical records of like residents residing in the facility to ensure that consents and care plan documentation aligns and that Pneumococcal vaccinations are administered per orders. On or before 04/30/2026, DON/Designee will provide education to licensed nursing personnel (including MDS nursing staff) regarding the following: 483.20(g)(h)(i)(j) Accuracy of F 0641 Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is §483.20(i) | |

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| F 0641 | Continued From page 14<br>Resident #11 revealed an order dated 09/26/25 for bilateral handrails to promote bed mobility due to weakness. Check placement every shift.<br><br>Review of the Minimum Data Set (MDS) assessment section P for Resident #11 dated 02/24/26 revealed bed rails were coded as a physical restraint which was used daily.<br><br>Review of the care plan for Resident #11 revealed it did not include documentation of restraint use for the resident.<br><br>Review of the medical record for Resident #11 revealed it did not include a restraint assessment.<br><br>Observation on 03/23/26 at 1:12 P.M. revealed Resident #11's bed had two small handrails attached to each side of the top of the resident's bed to utilize for bed mobility. The handrails did not inhibit the resident's movement in or out of the bed or otherwise restrain the resident.<br><br>2. Review of the medical record for Resident #20 revealed an admission date of 12/17/24 with diagnoses including | F 0641 | (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false Statement. Also, on or before 04/30/2026, DON/Designee will provide education to licensed nursing personnel (including MDS nursing staff) explaining that: DON/MDS/Designee will review nursing documentation when completing MDS assessments to ensure that accurate coding is reflected in the MDS coding, specifically when a resident is using grab bars as a mobility device (not a restraint) and/or Pneumococcal vaccinations are offered/provided/declined. Discrepancies should be addressed with the Director of Nursing prior to coding by the MDS coordinator. On or before 04/30/2026, DON/Designee will compile a list of like residents who have bed rails. On or before 04/30/2026, DON/Designee will review the compiled list of like residents who have bed rails and ensure there is a current and accurate "Side Rail Assessment" documented. On or before 04/30/2026, DON/Designee will ensure that care plans and | |

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| F 0641 | Continued From page 15<br>Wernicke's encephalopathy, psychotic disorder with hallucinations, and dementia.<br><br>Review of the vaccine consent form for Resident #20 dated 09/29/25 revealed the resident was offered and declined the pneumonia vaccine.<br><br>Review of the MDS assessment for Resident #20 dated 12/22/25 revealed the resident was not up to date with the pneumonia vaccine due to the vaccine not being offered.<br><br>Interview on 03/26/26 at 9:55 A.M. with Assistant Director of Nursing (ADON) #490 and MDS Nurse #514 on confirmed Resident #11 had handrails ordered for mobility purposes which were not assessed to restrain the resident and the MDS assessment dated 02/24/26 had been coded inaccurately. ADON #490 and MDS #514 additionally confirmed Resident #20 had been offered the pneumonia vaccine on 09/29/25 and had declined the vaccine and the MDS assessment dated 12/22/25 had been coded inaccurately. | F 0641 | physician orders accurately reflect the use of bedrails and results from the "Side Rail Assessment." On or before 04/30/2026, DON/Designee will review MDS assessment for residents using bedrails to ensure accurate data has been coded and reported regarding the use and reasoning of use of bedrails. On or before 04/30/2026, DON/Designee will compile a list of residents, and their Pneumococcal vaccination status is. On or before 04/30/2026, DON/Designee will complete a complete audit to ensure that Pneumococcal vaccination statuses are accurately reflected in the medical record (i.e. consents, care plans). On or before 04/30/2026, DON/Designee will perform a complete audit to review most recent MDS assessment to ensure that MDS assessment accurately reflects the resident's Pneumococcal vaccination status. QAA. This audit will list the resident identifier (facility identifier), if they utilize bedrails, date of their last "Side Rail Assessment" why they utilize bed rails, and ensure accurate documentation is reflected in physician orders, care plan, and the recent MDS assessment. QAA. This audit will list resident identifier (facility identifier), the status of their Pneumococcal vaccination (offered, administered, declined, etc.), and ensure that this information is accurately reflected in the care plan and recent MDS assessment. | |

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| F 0644 | Continued From page 16 | F 0644 | | |
| F 0644 SS=D | 483.20(e)(1)(2) Coordination of PASARR and Assessments<br>§483.20(e) Coordination.<br><br>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:<br><br>§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.<br><br>§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.<br><br>This STANDARD is not met as evidenced by:<br><br>Based on medical record review and staff interview, the facility failed to ensure Pre-admission Screening and Resident Reviews (PASARRs) were completed and | F 0644 | DON completed a head-to-toe physical assessment/observation on Resident #66 on 03/26/2026. It was determined that there were no negative effects related to the missing Pre-Admission Screening & Resident Review (PASARR) identified during Annual Survey. On or before 04/30/2026, LNHA/Designee will a PASAR referral for Resident #66. The facility will ensure receipt and incorporation of PASARR findings into the resident's medical record, care plan, and service upon completion, as appropriate. LNHA notified Resident #66's primary care provider on 03/26/2026 of findings noted during Annual Survey and that no negative effects were identified during head-to-toe assessment/observation. Primary care provider acknowledged the missing Pre-Admission Screening & Resident Review (PASARR) and that there were no negative effects related to the lack of behavioral monitoring. No new orders received from primary care provider. On or before 04/30/2026, LNHA/Designee will review other residents' medical records to ensure that current residents have a Pre-Admission Screening & Resident Review (PASARR) on file. Also, on or before 04/30/2026, LNHA/Designee will evaluate list of residents and their diagnosis list(s). LNHA/Designee will evaluate diagnoses and Pre-Admission Screening & Resident Reviews (PASARR) to ensure that any diagnosis of a mental disorder and/or intellectual disability have been captured on a Pre-Admission Screening & Resident Reviews (PASARR). Any missing Pre-Admission Screening & Reviews (PASARRs) will be completed. On or before | 04/30/2026 |

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| F 0644 | Continued From page 17<br>updated to reflect new qualifying diagnoses. This affected one (Resident #66) of four residents reviewed for PASARR accuracy. The facility census was 69 residents.<br><br>Findings include:<br><br>Review of the medical record for Resident #66 revealed an admission date of 05/14/23 with diagnoses including diabetes mellitus type two, depression, and mood disorders, and osteomyelitis.<br><br>Review of the most recent PASARR for Resident #66 dated 06/08/23 revealed it did not include a diagnosis of bipolar disorder type two.<br><br>Review of the diagnosis list for Resident #66 revealed a new mental health diagnosis of bipolar disorder type two was added on 08/20/25.<br><br>Review of the Minimum Data Set (MDS) assessment for Resident #66 dated 01/12/26 revealed the resident had moderately impaired cognition. | F 0644 | 04/30/2026, LNHA/Designee will educate Social Service Designee (SSD) in the following: 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. Also, on or before 04/30/2026, LNHA/Designee will also educate Social Service Designee (SSD) that a Pre-Admission Screening & Resident Review (PASARR) is required with all new admissions and with any new mental health or intellectual disability diagnoses. LNHA/Designee will complete audits x5 residents/medical records weekly x4 weeks; then as determined by QAA. The audits will ensure that PASARR referrals are made when a resident: • Newly admits to the facility • Have a new diagnosis of serious mental illness, intellectual disability (ID), or related condition, and/or • Have had a significant change in status indicating a potential PASARR Level II trigger, and/or The audit will include: • Review of admission records • Diagnosis lists • Psychiatric consults | |

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| F 0644 | Continued From page 18<br><br>Interview on 03/25/26 at 11:43 A.M.with Corporate Director of Nursing #99 verified the facility had not completed a new PASARR for Resident #66 following the addition on 08/20/25 of a new mental health diagnosis for the resident. | F 0644 | • MDS Section P • Existing PASARR documentation Any resident lacking a required PASARR or with incomplete PASARR documentation will be referred immediately for PASARR review. Company policy/procedure was reviewed and no additional changes are required at this time. Education and ongoing monitoring is sufficient in ensuring regulatory compliance. | |

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| F 0656 | Continued From page 19 | F 0656 | | |
| F 0656 SS=D | 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan<br>§483.21(b) Comprehensive Care Plans<br><br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br><br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br><br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br><br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. | F 0656 | DON completed a physical head-to-toe assessment/observation of Resident #66 on 03/26/26. No negative effects were identified related to care plan issues identified during the Annual Survey. LNHA notified Resident #66's primary care provider on 03/26/2026 of missing documentation regarding care plan and notified there was no harm or negative effects to the resident regarding this lack of documentation. Primary care provider acknowledged the missing care plan documentation related to care required while using oxygen, and no harm or negative effects. No new orders currently. Resident #66 passed away (was on hospice – not related to oxygen use or misuse) and his care plan was not updated prior to his passing. On or before 04/30/2026, DON/Designee will educate licensed nursing personnel regarding the following: §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of | 04/30/2026 |

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| F 0656 | Continued From page 20<br>(iv)In consultation with the resident and the resident's representative(s)-<br><br>(A) The resident's goals for admission and desired outcomes.<br><br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br><br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br><br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(iii) Be culturally-competent and trauma-informed.<br><br>This STANDARD is not met as evidenced by:<br><br>Based on medical record review and staff interview, the facility failed to develop a plan of care for residents who received oxygen on a continuous basis. This affected one (Resident #66) of 21 residents reviewed for care plans. The facility census was 69 residents.<br><br>Findings include: | F 0656 | rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. On or before 04/30/2026, DON/Designee will complete an audit of residents currently residing in the facility. This audit will include the resident identifier (facility identifier); reflect if a physician's order is in place for oxygen use; and if the care plan accurately reflects the use of oxygen. Don/Designee will complete weekly audits x5 medical records per week x4; then as determined by QAA. This audit will include the resident identifier (facility identifier); reflect if a physician's order is in place for oxygen use; and if the care plan accurately reflects the use of oxygen. | |

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| F 0656 | Continued From page 21<br><br>Review of the medical record for Resident #66 revealed an admission date of 05/14/23 with diagnoses including diabetes mellitus type two, depression, and mood disorders, and osteomyelitis.<br><br>Review of the Minimum Data Set (MDS) assessment for Resident #66 dated 01/12/26 revealed the resident had moderately impaired cognition.<br><br>Review of the care plan for Resident #66 last revised on 03/07/26 revealed there was no care plan to address the resident's care needs related to supplemental oxygen and oxygen use.<br><br>Review of the physician's orders for Resident #66 revealed an order dated 03/09/26 for oxygen at two to three liters per minute per nasal cannula to maintain oxygen saturation levels above 90 percent (%) every day and night shift.<br><br>Interview on 03/25/26 at 11:43 A.M. with Corporate Director of Nursing (DON) #99 verified the facility did not develop a care | F 0656 | | |

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| F 0656 | Continued From page 22<br>plan to address Resident #66's care needs related to supplemental oxygen and oxygen use. | F 0656 | | |

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| F 0677 | Continued From page 23 | F 0677 | | |
| F 0677 SS=D | 483.24(a)(2) ADL Care Provided for Dependent Residents<br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br><br>This STANDARD is not met as evidenced by:<br><br>Based on medical record review, observation, resident interview, staff interview, and review of the facility policy, the facility failed to ensure staff provided timely bathing and hair washing assistance for dependent residents. This affected one (Resident #8) of the three residents reviewed for activities of daily living (ADL) assistance. The facility census was 69 residents.<br><br>Findings include:<br><br>Review of the medical record for Resident #8 revealed an admission date of 11/27/25 with diagnoses including acute kidney failure, adult failure to thrive, and depression.<br><br>Review of the Minimum Data Set (MDS) assessment for Resident #8 dated | F 0677 | DON performed a physical, head-to-toe assessment/observation of Resident #8 on 03/26/2026. This assessment/observation revealed that no negative outcomes were experienced by Resident #8 regarding the missing shower documentation, greasy hair, or concern of lacking episodes of bathing/showering/hair care identified during Annual Survey. LNHA notified Resident #8's primary care provider on 03/26/2026 of missing shower documentation, greasy hair, and concerns for lacking episodes of bathing/showering/hair care identified during Annual Survey and that a physical, head-to-toe assessment/observation was completed, revealing no negative outcomes. Primary care provider acknowledged these findings and provided no new orders. Responsible Nurse reviewed Resident #8's bathing/shower schedule 04/09/26 to ensure shower/bed bath was scheduled appropriately. Resident previously moved rooms and bathing/shower scheduled was not updated, resulting in the above-described findings. Responsible Nurse adjusted Resident #8's bathing/shower schedule on 04/09/2026 to reflect her new room assignment with an associated bathing/shower schedule of every Tuesday and Saturday during dayshift (7a-7p). Resident #8 agreeable. DON added Resident #8's new bathing/shower schedule to Point-of-Care documentation on 04/09/2026 so that CNAs will be required to document bathing/showering episodes on Tuesdays, Saturdays, and as needed or requested. On or before 4/30/2026, DON/Designee will educate licensed and unlicensed nursing staff | 04/30/2026 |

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| F 0677 | Continued From page 24<br>11/27/25 revealed the resident was cognitively intact.<br><br>Review of the care plan for Resident #8 dated 12/11/25 revealed the resident was at risk for a self-care deficit with bathing, dressing, and feeding. Interventions included the following: encourage the resident to participate in planning day to day care, evaluate the resident's ability to perform self-care, minimize environment stimuli, provide assistance with ADLs as needed.<br><br>Review of the shower task list for Resident #8 initiated 11/27/25 revealed the resident was scheduled to receive showers on night shift on Sundays and Thursdays.<br><br>Review of the shower documentation for Resident #8 dated 02/26/26 through 03/25/26 revealed the resident received showers on 03/06/26 and 03/22/26. There were no additional showers documented during the 30-day time frame.<br><br>Observation on 03/24/26 at 8:45 A.M. of Resident #8 revealed the resident's hair | F 0677 | on the following: § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Also, on or before 04/30/2026, DON/Designee will educate licensed and unlicensed nursing personnel regarding the importance and requirement of providing bathing/showering per shower schedules. On or before 04/30/2026, DON/Designee will review residents' bathing/shower schedules to ensure residents are listed on shower schedules as appropriate. DON/Designee will complete weekly audits x5 medical records x4 weeks; then as determined by QAA. This audit will list the resident identifier (facility's identifier), when their bathing/shower episodes are scheduled, if the bathing/shower episode(s) have been documented as completed or at least offered per schedule, and if the resident appeared clean and well kept. | |

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| F 0677 | Continued From page 25<br>was greasy and appeared unwashed.<br><br>Interview on 03/24/26 at 8:46 A.M. with Resident #8 confirmed she preferred to have a shower or bed bath at least twice a week and to have her hair washed on those days. Resident #8 confirmed she had not had her hair washed in weeks and did not receive a shower or bed bath at least twice a week per her preference.<br><br>Observation on 03/26/26 at 9:05 A.M. of Resident #8 revealed the resident's hair was greasy and appeared unwashed.<br><br>Interview on 03/26/26 at 9:06 A.M. with Resident #8 confirmed she had still not received a shower or had her hair washed.<br><br>Interview 03/26/26 at 10:50 A.M. with the Director of Nursing. confirmed residents should receive showers and hair washing per their scheduled preference and staff were to document the showers and care in the residents medical record. The DON confirmed Resident #8 was documented to have received two showers or bed baths from 02/26/26 through 03/25/26 and was not | F 0677 | | |

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| F 0677 | Continued From page 26<br>documented to have refused any care.<br><br>Review of the facility policy titled Supporting Activities of Daily Living Supporting revised March 2018 revealed residents who were unable to carry out ADLs independently would receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.<br><br>This deficiency represents noncompliance investigated under Complaint Number 2647177. | F 0677 | | |

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| F 0684 | Continued From page 27 | F 0684 | | |
| F 0684 SS=D | 483.25 Quality of Care<br>§ 483.25 Quality of care<br><br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br><br>This STANDARD is not met as evidenced by:<br><br>Based on medical record review, staff interview, and review of facility policy, the facility failed to ensure staff obtained resident weights as ordered by the physician. This affected one (Resident #12) of five residents reviewed for nutrition. The facility census was 69 residents.<br><br>Findings include:<br><br>Review of the medical record for Resident #12 revealed an admission date of 02/02/26 with diagnoses including adult failure to thrive, chronic obstructive pulmonary disease (COPD), and protein calorie malnutrition. | F 0684 | DON performed a head-to-toe physical assessed Resident #12 on 03/26/26. There were no negative effects related to the residents' missing weight documentation that were identified during the Annual Survey. LNHA notified Primary care provider of missing weight documentation on 03/26/26. Primary care provider gave new orders to change weight frequency to weekly. On or before 4/30/26, DON/Designee will review residents' weight orders and ensure weights are scheduled in Point Click Care, per physician's orders. On or before 4/30/2026, licensed and unlicensed nursing staff will be educated on: § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Also, on or before 04/30/026, licensed and unlicensed nursing staff will be educated on: the importance and procedure of following weight order/care plan and ensuring proper documentation.<br>DON/Designee will perform audits x5 medical records weekly x4 weeks; then as determined by QAA. This audit will list a resident identifier (facility identifier), current weight order, and if the weight(s) were obtained per current physician's orders. Negative findings identified during the audits will be investigated / verified. Dietician will be alerted for review/intervention, PCP alerted for reporting/review/intervention, and responsible party alerted of any negative | 04/30/2026 |

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| F 0684 | Continued From page 28<br><br>Review of the physician's orders for Resident #12 revealed an order dated 02/02/26 for the resident to be weighed every Monday, Wednesday, and Friday at 6 A.M. due to COPD.<br><br>Review of the Minimum Data Set (MDS) assessment for Resident #12 dated 02/11/26 revealed the resident had severely impaired cognition.<br><br>Review of the weight record for Resident #12 dated February 2026 and March 2026 revealed weights were not documented on the following dates: 02/06/26, 02/09/26, 02/11/26, 02/16/26, 02/18/26, 02/20/26, 02/23/26, 02/25/26, 03/02/26, 03/04/26, 03/09/26, 03/11/26, 03/13/26, 03/16/26, 03/18/26, 03/23/26. There was no documentation of resident refusal of weights.<br><br>Interview on 03/26/26 at 10:30 A.M with the Director of confirmed Resident #12 had a physician's order to be weighed every Monday, Wednesday, and Friday at 6:00 A.M. due to COPD. The DON confirmed the facility had no documented weights or refusals of weights for the following dates in February 2026 and March 2026: 02/06/26, 02/09/26, 02/11/26, 02/16/26, 02/18/26, 02/20/26, 02/23/26, 02/25/26, 03/02/26, 03/04/26, | F 0684 | findings and/or new orders or concerns. | |

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| F 0684 | Continued From page 29<br>03/09/26, 03/11/26, 03/13/26, 03/16/26, 03/18/26, 03/23/26<br><br>Review of the facility policy titled Weights Policy and Procedure undated the facility staff would weigh all residents upon admission and weekly for 4 weeks and then monthly after admission unless specific diagnoses indicated a daily weight. Additional weights might be requested by the dietitian, physician or nursing staff as needed. All resident weights should be recorded in the weight/vital section of the electronic medical record. | F 0684 | | |

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| F 0697 | Continued From page 30 | F 0697 | | |
| F 0697 SS=D | 483.25(k) Pain Management<br>§483.25(k) Pain Management.<br><br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br><br>This STANDARD is not met as evidenced by:<br><br>Based on medical record review, staff interview, resident interview, and review of facility policy, the facility failed to ensure staff routinely monitored resident pain levels. This affected one (Resident #20) of five residents reviewed for unnecessary medications. The facility census was 69 residents.<br><br>Findings include:<br><br>Review of the medical record for Resident #20 revealed an admission date of 12/17/24 with diagnoses including Wernicke's encephalopathy, psychotic disorder with hallucinations, and dementia.<br><br>Review of the care plan for Resident #20 dated 05/15/25 revealed the resident was | F 0697 | DON assessed Resident #20 on 03/26/2026. There were no negative effects related to the resident's lack of Pain Assessment completion that was identified during the Annual Survey. LNHA notified Primary care provider of lack of Pain Assessment completion on 03/26/2026. Primary care provider has no new orders currently. On or before 04/30/2026, DON/Designee will meet with interdisciplinary team (IDT) to review facility policy & procedure regarding monitoring pain. At this time, the IDT will ensure that the facility's policy & procedure requires all like residents' pain be monitored by licensed nursing staff every shift. On or before 04/30/2026, licensed nursing staff will be educated on: §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Also, on or before 4/30/2026, licensed nursing staff will be educated on the requirement that pain observation & documentation must occur every shift for all like residents.<br>DON/Designee will perform Pain Assessment audits of x5 medical records x4 weeks; then as determined by QAA to ensure proper documentation is complete. The audit will list identifier (facility identifier), current pain observation reflected in physician's order; pain observation completion; and follow-up interventions completed for any reports of pain | 04/30/2026 |

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| F 0697 | Continued From page 31<br>at risk for pain/discomfort. Interventions included the following: administer medications as ordered/as warranted, monitor for effectiveness, assess the residents pain/location/duration/frequency/intensity and document negative findings.<br><br>Review of the physician's orders for Resident #20 revealed an order 07/23/25 for Tylenol two 325 milligram (mg) tablets every six hours for left hip pain.<br><br>Review of the Minimum Data Set (MDS) assessment for Resident #20 dated 12/22/25 revealed was cognitively intact and had occasional pain which made it hard to sleep during five days of the review period.<br><br>Review of the Medication Administration Records (MARs) for Resident #20 dated February 2025 and March 202 revealed there was no order for routine pain monitoring and there was no documentation of pain assessment since 02/25/26.<br><br>Interview on 03/24/26 at 1:50 P.M with the Director of Nursing (DON) confirmed all | F 0697 | | |

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| F 0697 | Continued From page 32<br>residents should have a set day when their pain assessment was to be completed. The DON confirmed Resident #20's medical record did not include a physician's order for routine pain monitoring and the resident's MARS dated February 2026 and March 2026 had no documented pain assessment since 02/25/26.<br><br>Interview on 03/26/26 at 9:22 A.M. with Resident #20 confirmed his pain level fluctuated but was manageable, and he received scheduled medication for pain which was typically effective.<br><br>Review of the facility policy titled Pain Management and Assessments undated, revealed all residents would be monitored for pain every shift by nursing and this information should be tracked on the pain section of the resident's MAR flow sheet. | F 0697 | | |

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| F 0812 | Continued From page 33 | F 0812 | | |
| F 0812 SS=F | 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary<br>§483.60(i) Food safety requirements.<br><br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br><br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br><br>(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.<br><br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br><br>This STANDARD is not met as evidenced by: | F 0812 | No resident experienced negative effects related to the unsealed box of dried onion flakes observed on 03/23/2026 @ 09:21 am. No resident experienced negative effects related to the undated bag of flour tortillas that were open-to-air and undated, observed in stand-up freezer #1 on 03/23/2026 @ 09:23 am. No resident experienced negative effects related to the undated and unlabeled milkshake that was observed in stand-up freezer #1 on 03/23/2026 @ 09:23 am. No resident experienced negative effects related to the unlabeled and undated visibly spoiled lettuce, package of cheese, and box of hamburgers observed in the kitchenette next to the main kitchen refrigerator on 03/23/2026 @ 09:27 am. No resident experienced negative effects related to the unsealed and open-to-air bag of turkey lunchmeat and bag of ham lunchmeat observed in stand-up refrigerator #1 on 03/23/2026 @ 09:39 am. No resident experienced negative effects related to the individually packaged servings of orange juice, prune juice, and apple juice; as well as individually wrapped dinner rolls and doughnuts observed in stand-up freezer #2 which contained two thermometers reading 48 degrees Fahrenheit, on 03/23/2026 @ 09:42 am. No resident experienced negative effects related to the unsealed bag of cheese and gag of thawed frozen strawberries with an open date of 03/07/2026, observed in the stand-up refrigerator #4, on 03/23/2026 @ 09:39 am. No resident experienced negative effects related to the unsealed bag of chicken fingers observed in freezer #3 on 03/23/2026 @ 09:50 am. No resident experienced negative effects related to the labeled [with | 04/30/2026 |

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| F 0812 | Continued From page 34<br>Based on observation and staff interview, the facility failed to store food in a manner to prevent food born illness. This had to potential to affect all 69 residents residing in the facility who received food from the kitchen. The facility census was 69 residents.<br><br>Findings include:<br><br>1.Observation on 03/23/26 at 9:21 A.M. of the revealed there was a box of dried onion flakes in a bag which was unsealed and open to air.<br><br>Interview on 03/23/25 at 9:22 A.M. with the Dietary Manager (DM) confirmed the onion flakes were not properly sealed and should have been discarded.<br><br>2.Observation on 03/23/26 at 9:23 A.M. of stand-up freezer #1 revealed it contained an undated bag of flour tortillas which were open to air and an undated and unlabeled milkshake.<br><br>Interview on 03/23/26 at 9:24 A.M. with the DM confirmed the tortillas were not dated nor properly sealed and should have been discarded. The DM confirmed the milkshake was undated and unlabeled and should have been discarded. | F 0812 | resident's name] meat & crackers which was undated; and a premade salad in a takeout container unnamed and undated, observed in the therapy gym refrigerator on 0326/2026 @ 12:16 pm. No resident experienced negative effects related to the partially consumed milkshake that was open-to-air with no name of date and a half-gallon container of vanilla ice cream that was opened, unnamed and undated, observed in the therapy gym freezer. LNHA notified Medical Director on 04/06/2026 of the findings noted during Annual Survey that involved inappropriately stored foods/drinks and that no negative effects were identified in any resident related to the inappropriately stored foods/drinks. No new orders were received from Medical Director. LNHA/Designee will educate licensed and unlicensed personnel in the following: 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. LNHA/Designee will complete daily rounds, | |

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| F 0812 | Continued From page 35<br><br>3. Observation on 03/23/26 at 9:27 A.M. of kitchenette next to main kitchen refrigerator revealed it contained the following unlabeled and undated items: a bag of visibly spoiled lettuce, a package of cheese, a box of hamburgers.<br><br>Interview on 03/23/26 at 9:28 A.M. with the DM confirmed the lettuce, cheese, and hamburgers in the refrigerator were unlabeled and undated and should have been discarded.<br><br>4. Observation on 03/23/26 at 9:29 A.M. of stand-up refrigerator #1 revealed it contained a bag of turkey lunchmeat and a bag of ham lunchmeat both unsealed and open to air.<br><br>Interview on 03/23/26 at 9:30 A.M. with the DM confirmed the turkey and ham were not properly sealed and should have been discarded.<br><br>5. Observation on 03/23/26 at 9:42 A.M. of stand-up freezer #2 revealed it contained two thermometers which read 48 degrees Fahrenheit (F). The freezer contained individually packaged servings of orange juice, prune juice, and apple juice in boxes labeled to keep the juices | F 0812 | observing food storage areas, ensuring that all items are labelled, dated, unexpired, and stored appropriately (i.e., appropriate temperature levels in refrigerators (<41 degrees Fahrenheit), freezers (at or below 0 degrees Fahrenheit). Issues will be addressed upon recognition of issue. Also, LNHA/Designee educated Dietary Manager & Therapy Director on 03/26/2026 that staff foods/drinks must be stored in separate refrigerators/freezers than residents. Further, all items in the resident's refrigerators/freezers must be dated/labeled and expiration date(s) observed. Any expired, unlabeled, or undated items are to be discarded straight away. Dietary Manager also educated on 03/26/2026 that refrigerators storing food and beverages must meet the temperature threshold of <41 degrees Fahrenheit (refrigerator) or 0 degrees or less (freezer). Freezer that was being utilized as a refrigerator was removed from service on 03/26/2026. Juices were moved to an actual storage refrigerator, within acceptable temperature range. There is adequate storage space for refrigerated and frozen items, so replacement of malfunctioning freezer is not necessary, but on or before 04/30/2026, the interdisciplinary team (IDT) will meet and discuss benefits of purchasing a new refrigerator/freezer and determine necessity. If necessary, quotes will be obtained by LNHA and purchase made. Dietary Staff will observe & record refrigerator and freezer temperatures every shift, at least twice daily to ensure temperatures are within acceptable limits (refrigerator < 41 degrees Fahrenheit and freezer at or below 0 degrees Fahrenheit). | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (x2) multiple construction | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366143 | a. building _____ b. wing _____ | 03/26/2026 |

| name of provider or supplier | street address, city, state, zip code |
|---|---|
| ADAMS COUNTY MANOR | 10856 STATE ROUTE 41 WEST UNION OH, 45693 |

| (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 0812 | Continued From page 36<br>at temperatures below 38 degrees F. The freezer also contained boxes of individually wrapped dinner rolls and doughnuts.<br><br>Interview of 03/23/26 at 9:43 A.M. with the DM confirmed the freezer temperature was 48 degrees F and needed to be repaired and the facility was awaiting estimates regarding the cost of the repair. The DM further confirmed the instructions for the juices indicated they were to be stored below 38 degrees F.<br><br>Interview on 03/26/26 at 3:10 P.M. with the Administrator confirmed he was aware there was a freezer in the kitchen that was being looked at to repair or replace but he was unaware that food and beverages were being stored in it.<br><br>6. Observation on 03/23/26 at 9:47 A.M. of stand-up refrigerator #4 revealed it contained an unsealed bag of cheese and a bag of thawed frozen strawberries with an open date of 03/07/26.<br><br>Interview on 03/23/26 at 9:48 A.M. with the DM confirmed the cheese was not properly sealed and the strawberries had expired and both items should have been discarded. | F 0812 | Any failing equipment will be removed from service immediately and reported to Maintenance for corrective action. Dietary Manager will be responsible for ensuring this occurs. Compliance will be determined by daily review of Dietary staff documentation by Dietary Manager. Dietary Manager audited refrigerators located in the kitchen, kitchenette, and Therapy gym on 03/26/2026. Undated, unlabeled, and expired items were discarded. Dietary Manager also verified that all refrigerators and freezers in use in the kitchen, kitchenette, and Therapy gym were within appropriate temperature range(s) (< 41 degrees refrigerator & at or below 0 freezer) on 03/26/2026. LNHA/Designee will complete audits that determine if foods & drinks are being appropriately stored and that Dietary staff are consistently and appropriately monitoring refrigerator and freezer temperatures (below 41 degrees Fahrenheit). Inappropriately stored items will be addressed straight away. These audits will be completed on at least 3 refrigerators/freezers every week x4; then as determined by QAA | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (x2) multiple construction | (X3) DATE SURVEY COMPLETED |
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| | 366143 | a. building _____ b. wing _____ | 03/26/2026 |

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|---|---|---|---|---|
| F 0812 | Continued From page 37<br><br>7.Observation on 03/23/26 at 9:50 A.M of freezer #3 revealed it contained a bag of chicken fingers unsealed and open to air.<br><br>Interview on 03/23/26 at 9:51 A.M. with the DM confirmed the chicken fingers were not properly sealed and should have been discarded.<br><br>8. Observation on 03/26/26 at 12:16 P.M of the refrigerator in the therapy gym used to store resident food revealed it contained meat and crackers labeled with a resident name but undated and a premade salad in a takeout container unnamed and undated. Observation of the freezer compartment revealed it contained a partially consumed milkshake open to air with no name of date and a half-gallon container of vanilla ice cream opened, unnamed and undated.<br><br>Interview on 03/26/26 at 12:17 P.M. with Therapy Manager ™ #97 confirmed the items in the refrigerator/freezer were not properly labeled and dated and should have been discarded. | F 0812 | | |