STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	366144	a. building _____ b. wing _____	06/03/2025

name of provider or supplier	street address, city, state, zip code
MENNONITE MEMORIAL HOME	**410 W ELM STREET BLUFFTON OH, 45817**

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F 0000	INITIAL COMMENTS COMPLAINT INVESTIGATION MASTER COMPLAINT NUMBER OH00166006 AND COMPLAINT NUMBER OH00165153 ADMINISTRATOR: Lance Nickles, #6851 CERTIFIED BED CAPACITY: 60 CENSUS IN HOUSE: 58 The following deficiencies are based on the complaint investigation completed on 06/03/25.	F 0000		

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

LANCE.NICKLES | 06/25/2025

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 0580	Continued From page 1	F 0580		
F 0580 SS=D	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or	F 0580	Plan of Correction F 0580 This Plan of Correction is prepared and executed because it is required by the provision of the State and Federal regulations and not because Mennonite Memorial Home agrees with the allegations and citations listed on this statement of deficiencies. Mennonite Memorial Home maintains that the alleged deficiencies do not, individually or collectively, jeopardize the health and safety of the residents, nor are they of such a character as to limit our capacity to render adequate care as prescribed by regulation. This Plan of Correction shall operate as the facility's written credible allegation of compliance as of 6/18/2025. By submitting this Plan of Correction, Mennonite Memorial Home does not admit to the accuracy of the deficiencies. This Plan of Correction is not meant to establish any standard of care, contract, obligation, or position and Mennonite Memorial Home reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding. Immediate Corrective Action Taken for the Identified Resident(s): • The resident identified in this survey had been identified by the facility. The staff at the facility attempted to obtain contact information for the resident's husband/responsible party. The medical record was updated accordingly. Identified other residents having potential to be affected by the same deficient practice and corrective action: • Social Service reviewed all resident profile sheets on 4/23/2025 to assure emergency contacts were listed for all current residents living in the facility. All other residents had an emergency contact listed	06/18/2025

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F 0580	Continued From page 2 (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to timely notify a resident's representative of change of condition in the resident. This affected one (#19) of three residents reviewed for change of condition. The facility census was 58. Findings included: Review of Resident #19's medical record revealed the resident was admitted on 04/22/25 with diagnosis of malignant of cardia, lymph, and lung and diabetes type two.	F 0580	with a phone number. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: • Staff education given on 6/6/2025 to Social Service Department by Administrator or his designee on filling out profile page prior to admissions. Social Service will assure that resident #19 or like resident's responsible party information is correct for any needed notifications. Ongoing Monitoring so this deficient practice will not recur: • The Director of Nursing or designee will monitor resident's profile sheet admitted 6/3/2025 or after for 4 weeks to assure proper responsible party information is present on profile sheet. • The DON or designee will preform weekly audits for 4 weeks on a sample of residents with a change in condition to ensure proper notification and documentation. This started on +6/6/2025. • Results will be reported monthly to the Quality Assurance Committee	

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F 0580	Continued From page 3 Review of Resident #19 nursing note dated 04/23/25 at 5:20 A.M. revealed Resident #19 was hard to arouse, opens eyes to name but then closes eyes. Finger blood sugar was 150. At 5:23 A.M., nine-one-one (911) for hospital transportation was called, at 5:25 A.M. notification was made to the physician, at 5:26 A.M. emergency squad arrived, at 5:27 A.M. report was called to the hospital and at 5:38 A.M. squad left facility for route to hospital. Husband was not notified due to not having husband's contact information. Review of Resident #19's of nursing note date 04/23/25 at 12:44 P.M. revealed Resident #19's husband came to facility unaware Resident #19 was transferred to hospital. Staff collected husband's contact information and shared information with the hospital. The physician spoke with husband. Interview on 06/03/25 at 9:28 A.M. with Licensed Practical Nurse (LPN) #63 revealed she was the nurse that completed the nursing portion of the admission assessment for Resident #19. LPN #63 stated Resident #19 was alert, answering questions appropriately, and understood questions. LPN #63 stated Resident #19's husband was present in the room during admission assessment. LPN #63 verbalized social worker completes the demographic information and gets family phone numbers. Nursing does not look at demographics during the	F 0580		

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F 0580	Continued From page 4 admission process. LPN #63 confirmed she did not obtain Resident #19's representative information on who to contact in the event of an emergency or change of condition. LPN #63 confirmed when Resident #19 was sent to the hospital on 04/23/25 the family was not timely notified of the hospitalization because the facility didn't have the contact information. Interview on 06/03/25 at 10:00 A.M. with Licensed Social Worker (LSW) #65 revealed LSW #65 gets most of her contact information for resident usually from the hospital demographic page that is faxed from the hospital before the resident arrives and then from resident/family. LSW #65 confirmed the facility did not obtain Resident #19's representative information on who to contact in the event of an emergency or change of condition. This deficiency represents non-compliance investigated under Complaint Number OH00165153.	F 0580		

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F 0677	Continued From page 5	F 0677		
F 0677 SS=E	483.24(a)(2) ADL Care Provided for Dependent Residents §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; This STANDARD is not met as evidenced by: Based on record review, staff interviews and review of facility policy, the facility failed to ensure residents were provided with assistance for activities of daily living (ADL's). This affected 10 (#10, #11, #12, #13, #14, #15, #16, #20, #21 and #22) residents residing on the secured dementia unit. The facility census was 58. Findings include: Review of medical record for Resident #10 revealed admission date of 04/21/25 with diagnoses including pneumonia, atrial fib and heart failure. The resident remained in the facility. Review of Resident #10's admission Minimum Data Set (MDS) dated 04/27/25 revealed a Brief Interview Mental Status (BIMS) score of 15 indicating intact cognition. She required supervision for eating, max assist for toileting and moderate assistance for bed mobility and transfers. Review of medical record for Resident #11 revealed admission date of 09/24/19	F 0677	Plan of Correction F 0677 This plan of correction is prepared and executed because it is required by the provision of the State and Federal regulations and not because Mennonite Memorial Home agrees with the allegations and citations listed on this statement of deficiencies. Mennonite Memorial Home maintains that the alleged deficiencies do not, individually or collectively, jeopardize the health and safety of the residents, nor are they of such a character as to limit our capacity to render adequate care as prescribed by regulation. This Plan of Correction shall operate as the facility's written credible allegation of compliance as of 6/18/2025. By submitting this Plan of Correction, Mennonite Memorial Home does not admit to the accuracy of the deficiencies. This Plan of Correction is not meant to establish any standard of care, contract, obligation, or position and Mennonite Memorial Home reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; • ADL care was immediately provided and documented, including hygiene, toileting, repositioning, oral care, and dressing when original issue was noted on 5/17/25. • The Care Plans were reviewed and confirmed current ADL needs. • Staff assigned to these residents were reeducated on expectations for complete and timely ADL care on 6/4/2025 and 6/6/2025. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action	06/18/2025

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F 0677	Continued From page 6 with diagnoses including Parkinson's, dementia, stroke, and dysphagia. The resident remained at the facility. Review of Resident #11's annual MDS dated 05/2/25 revealed she had moderately impaired cognition and she/he required limited assistance for eating, extensive one person assistance for bed mobility, toileting and transfers. Review of medical record for Resident #12 revealed admission date of 11/25/24 with diagnoses including dementia with severe psychotic disturbances, dementia and hypertension. The resident remained in the facility. Review of Resident #12's quarterly MDS dated 03/06/25 revealed BIMS score of 04 indicating severely impaired cognition. She required supervision for eating, bed mobility, transfers and extensive assistance for toileting. Review of medical record for Resident #13 revealed admission date of 07/06/17 with diagnoses including dementia, anxiety, psychotic disorder with delusions. The resident remained at the facility. Review of Resident #13's quarterly MDS dated 05/14/25 revealed moderately impaired cognition. She required extensive two-person assistance with toileting, one-person assistance for bed mobility, dependent for transfers and limited assistance for eating.	F 0677	will be taken; • A full audit of residents with ADL care needs was completed by 6/4/2025. • Direct observations, review of documentation, and staff interviews were conducted for all at risk residents. • Any deficiencies identified were promptly addressed with staff follow-up and care plan updates as needed. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; • Staff education provided to all direct care staff (RNs, LPNs, CNAs) by the Director of Nurses or her designee on 6/6/25. Education on care needs of Residents #10, #11, #12, #13, #14, #15, #16,, #20, #21, #22, and other residents that require assistance, on all ADLs including hygiene, toileting, repositioning, oral care and dressing. • Staff education on timely documentation in Point of Care. • Recognizing and reporting any unmet care needs or refusals of care. • Staffing patterns and assignments were reviewed and adjusted to ensure adequate coverage for dependent residents. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. • The Director of Nursing or her designee will monitor the residents 3x/week x 4 weeks to assure dignity for the resident's grooming needs and that residents are clean and dry. Residents will also be checked that they have received and eaten their meals as they desire. Noncompliance will result in immediate reeducation and progressive discipline if necessary. Audits were initiated on 5/19/2025. • Audit results will be reviewed during monthly QAPI meetings monthly x 3 months to ensure	

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F 0677	Continued From page 7 Review of medical record for Resident #14 revealed admission date of 02/14/25 with diagnoses including paraplegia and dementia. The resident remained at the facility. Review of Resident #14's quarterly MDS dated 02/20/25 revealed with a BIMS score of 11 indicating impaired cognition. She required set up assistance for eating, maximum assistance for bed mobility and was dependent for toileting hygiene and transfers. Review of medical record for Resident #15 revealed admission date of 08/08/24. The resident was admitted with diagnoses including Parkinson's. The resident remained in the facility. Review of Resident #15's quarterly MDS dated 05/06/25 revealed with a BIMS score of 14 indicating intact cognition. She was independent with her ADL's. Review of medical record for Resident #16 revealed admission date of 11/14/22 with diagnoses including Alzheimer's Disease and dementia. The resident remained at the facility. Review of Resident #16's quarterly MDS dated 03/12/25 revealed severely impaired cognition. She required supervision with eating, maximum assistance with bed mobility and was dependent for transfers and toileting	F 0677	ongoing compliance.	

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F 0677	Continued From page 8 hygiene. Review of medical record for Resident #20 revealed an admission date of 11/30/18 with diagnoses including Alzheimer's Disease, dementia and anxiety. The resident remained at the facility. Review of Resident #20's quarterly MDS dated 03/15/25 revealed a Brief Interview Mental Status (BIMS) score of 01 indicating severely impaired cognition. She required extensive one-person assistance for her ADL's. Review of medical record for Resident #21 revealed admission date of 11/30/18 admitted with diagnoses including atherosclerotic heart disease of native coronary artery without angina pectoris, dysphagia and heart failure. The resident remained at the facility. Review of Resident #21's annual MDS dated 05/15/25 revealed a BIMS score of 03 indicating severely impaired cognition. The resident was she/he required extensive two-person assistance for bed mobility, transfers, toileting and limited assistance for eating. Review of medical record for Resident #22 revealed admission date of 03/28/23 admitted with diagnoses including unspecified dementia with severe psychotic disturbance, behavioral disturbance, anxiety and depression. The	F 0677		

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F 0677	Continued From page 9 resident remained at the facility. Review of Resident #22's quarterly MDS dated 04/29/25 revealed with a BIMS score of 03 indicating severely impaired cognition. She required extensive one-person assistance for eating. And supervision for bed mobility, toileting and transfers. Review of the facility supplied statement from Certified Nursing Assistant (CNA) #74 documented she had worked on 05/16/25 and when she returned on 05/17/25 the residents on the secured dementia were dressed in the same clothes and required incontinence care. Three staff attended to the resident's ADL needs. Interview on 06/03/25 at 9:35 with CNA #67 revealed she had worked on 05/18/25. CNA #67 stated an agency aid (CNA #75) had worked a double shift prior to her arrival and had left without giving her report. CNA #67 shared several residents were asleep in their recliners and the same clothes as when she left her the day prior. CNA #67 stated a nurse was notified and management had investigated the incident. Interview on 06/03/25 at 2:48 P.M. with the Director of Nursing (DON) revealed she was on call on 05/18/25 and was informed by nursing that CNA #74 had reported when she arrived for her shift the residents were in the same clothes as she	F 0677		

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F 0677	Continued From page 10 had left them in the previous day and required incontinence care. The DON shared an investigation was initiated and a Self-Reported Incident (SRI) was created. The DON stated CNA #75 had worked the front part of the 100 hall on 05/16/25 without incident. On 05/17/25, CNA #75 worked a double shift on the back part of the hall and did not provide the resident's assistance with their ADL's as evidenced by the residents had not been changed out of the clothes from the previous day and required incontinence care. The DON stated skin sweeps were completed without concern and two cognitively intact resident's were interviewed and no concerns/outcomes were identified. The DON confirmed this affected 10 (#10, #11, #12, #13, #14, #15, #16, #20, #21 and #22) residents residing on the secured dementia unit. The DON placed CNA #75 and two agency nurses who worked with him on the Do Not Return (DNR) list for the facility. The DON also reported CNA #75 to the Ohio Department of Health. The DON stated audits were initiated to ensure residents on the back of the 100 hall were well-groomed, had received/eaten meal and were clean and dry. These audits were performed three times a week and she provided documentation they had been completed without incident at the time of the survey. The DON shared the facility CNA's had been educated to perform walking rounds at the start/end of their shifts to ensure ADL's were completed. The DON did acknowledge	F 0677		

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F 0677	Continued From page 11 agency staff were still being scheduled on all shifts and had not provided this information. The DON verified there was no documentation staff had received education to prevent another incident. Interview on 06/03/25 at 3:59 P.M. with CNA #69 revealed walking rounds were not completed at the start of her shift. Interview on 06/03/25 at 4:06 P.M. with Registered Nurse (RN) #71 revealed she encouraged the CNA's to do walking rounds to ensure residents were clean and dry. RN #71 shared at least one to two times weekly she was informed by her CNA's that resident's required incontinence care at the start of the shift. When she asked them if walking rounds were completed, they informed her they had not. Review of the facility policy, "Activities of Daily Living" revised 03/2018 documented appropriate care and services would be provided for residents who were unable to carry out ADL's independently and in accordance with the plan of care. This deficiency represents non-compliance investigated under Complaint Number OH00166006.	F 0677		