STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365045	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillebrand Nursing and Rehabilitation Center	4320 Bridgetown Road Cincinnati, OH 45211

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review and staff interview, the facility failed to ensure a Registered Nurse (RN) was working in the facility for at least eight consecutive hours a day seven days a week. This had the potential to affect all of the residents residing in the facility. The facility census was 98 residents.Findings include: Review of the facility staffing schedules revealed on 03/22/26 the census was 96 residents and there was no RN on the schedule for this date. Interview on 03/26/26 at 1:04 P.M. with the Director of Nursing (DON) verified there was no RN working during the 24 hours on the date of 03/22/26. The DON verified there needed to be an RN working eight hours of each day. Interview on 03/26/26 at 1:30 P.M. with the Administrator verified there was no RN working on 03/22/26 and an RN was required to work eight hours of each day.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure residents experienced a dignified dining experience. This affected one (Resident #104) of three residents reviewed for dignity. The facility census was 98 residents. Findings include:Review of the medical record for Resident #104 revealed an admission date of 07/21/23 with diagnoses including essential tremors, epilepsy, Alzheimer's disease, anxiety disorder and dysphagia. Review of the Minimum Data Set (MDS) assessment for Resident #104 dated 01/02/26 revealed the resident had severe cognitive impairment and required assistance with meals. Observations of the afternoon meal in the dining room on 03/23/26 at 12:00 P.M. revealed Resident #104 was seated at a table with other residents. Certified Nursing Assistant (CNA) #329 brought Resident #104's tray to the table and stood over the resident and began feeding the resident large bites. Resident #104 pushed CNA #329's hand away. CNA #329 did not provide the resident with the opportunity to feed herself, and the CNA remained standing over the resident during the entire meal continuing to put large bites of food into the resident's mouth. Interview on 03/23/26 at 12:30 P.M. with Licensed Practical Nurse (LPN)#104) confirmed CNA #329 should have sat down next to Resident #104 at eye level and should have assisted as the resident fed herself. Review of the facility policy titled Mealtimes undated revealed meals should foster resident independence and improve their quality of life.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on medical record review, observation, resident interview, staff interview, and review of the facility policy, the facility failed to ensure resident call lights were accessible to the resident. This affected one (Resident #86) of three residents reviewed for accidents and hazards. The facility census was 98 residents. Findings include: Review of the medical record for Resident #86 revealed an admission date of 07/22/23 with diagnoses including vascular dementia, respiratory failure, and dysphagia. Review of the care plan for Resident #86 dated 12/10/25 revealed the resident was at risk for falls related to deconditioning, and gait and balance problems. Interventions including the following: provide a safe environment, ensure the call light was working, ensure the call light was within reach. Review of the Minimum Data Set (MDS) for Resident #86 dated 03/04/26 revealed the resident was cognitively intact and required staff assistance with activities of daily living (ADLs.) Observation on 03/23/26 at 12:21 P.M. of Resident #86 revealed the resident was sitting up in a wheelchair beside his bed and was yelling out for help. The resident's call light was wrapped around the bed rail out of the resident's reach, and the resident was unable to get to the call light independently. Interview on 03/23/26 at 12:21 P.M. of Resident #86 confirmed he needed assistance and could not reach or get to his call light. Observation on 03/23/26 at 12:24 PM revealed Certified Nurse Assistant (CNA) #329 entered Resident #86's after being notified and assisted the resident and then exited the room. CNA #329 did not place the resident's call light in reach. Interview on 03/23/26 at 12:26 P.M. with CNA #329 confirmed Resident #86 was able to use his call light to summon assistance, but the call light was out of the resident's reach, and the resident was unable to get to it. CNA #329 confirmed staff should always ensure resident call lights are in reach before leaving the resident's room. Review of the facility policy titled Resident Call System dated 11/01/25 revealed each resident when not in direct observation of staff would have the call light readily accessible. Purposeful removal or displacement of the call light by staff members was prohibited.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure advance directives were accurate. This affected two (Residents #1 and #11) of three residents reviewed for advance directives. The facility census was 98 residents. Findings include: 1.Review of the medical record for Resident #1 revealed an admission date of 10/11/24 with diagnoses including unspecified bacterial pneumonia, acute pulmonary edema, and Parkinsonism unspecified.Review of the physician's orders for Resident #1 revealed an order dated 12/11/25 for the resident to be a full code. Review of the Minimum Data Set (MDS) assessment for Resident #1 dated 12/16/25 revealed the resident was cognitively intact and required staff assistance with activities of daily living (ADLs.) Review of a paper form in Resident #1's chart undated revealed the resident's code status was do not resuscitate comfort care-arrest (DNRCC-A). Interview on 03/24/26 at 2:29 P.M. with Licensed Practical Nurse (LPN) #114 verified the physician's order in the electronic health record was for Resident #1 to be a full code and there was a signed DNRCC-A form in the paper chart, and it was unclear which code status was correct. 2. Review of the medical record for Resident #11 revealed an admission date of 06/28/25 with diagnoses including hypertensive heart disease, chronic kidney disease, and cerebral infarction Review of the physician orders for Resident #11 in the electronic health record revealed an order dated 06/28/25 for a code status of DNRCC - Arrest. Review of the MDS assessment for Resident #11 dated 12/30/25 revealed the resident was cognitively intact and required staff assistance with ADLs. Review of the paper chart for Resident #11 revealed it contained a paper code dated 06/10/25 for DNRCC-A and an undated form for DNRCC. Interview on 03/24/26 at 2:21 P.M. with LPN #114 verified the physician order in the electronic health record was for Resident #11 to be a DNRCC-A and there were two paper forms in the chart, one for DNRCC-A and another for DNRCC. LPN #114 confirmed it was unclear which code status was correct. Review of the facility policy titled Advance Care Planning revised 04/28/25 revealed the charge nurse or designee would notify the physician of advance directives so that appropriate orders could be documented in the resident's medical record and plan of care.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on medical record review, review of facility Self-Reported Incidents (SRIs), review of staff witness statements, observation, staff interview, and review of the facility policy, the facility failed to ensure residents were free from verbal/emotional abuse. This affected one (Resident #104) of three residents reviewed for abuse. The facility census was 98 residents.Findings include:Review of the medical record for Resident #104 revealed an admission date of 07/21/23 with diagnoses including essential tremors, epilepsy, Alzheimer's disease, anxiety disorder and dysphagia. Review of the Minimum Data Set (MDS) assessment for Resident #104 dated 01/02/26 revealed the resident had severe cognitive impairment and required assistance with meals. Review of the facility SRI initiated 03/23/26 and completed 03/27/26 revealed the facility's investigation determined Certified Nursing Assistant (CNA) #329 had verbally/emotionally abused Resident #104. CNA #329 was terminated from employment as a result of the abuse. Review of the SRI included review of a signed witness statement per CNA #329 dated 03/23/26 which revealed the aide acknowledged she was feeding Resident #104 and when the resident spilled her drink, the aide sighed, took her gloves off, and pointed at the resident. Review of the SRI included review of a signed witness statement per LPN #920 dated 03/23/26 which revealed the Surveyor reported to LPN #920 that CNA #329 was standing over and feeding Resident #104 and the aide had taken off her gloves, thrown them on the table, and the aide pointed her finger in the resident's face. LPN #920 then sent CNA #329 out of the dining room and took over feeding Resident #104. Review of the SRI included review of a signed witness statement per LPN #108 undated revealed she was doing rounds in the facility with the Medical Director (MD) when another state Surveyor approached the MD and indicated an aide had yelled at a resident for spilling her drink. LPN #108 observed CNA #329 sitting at the desk after LPN #920 had told the aide to leave the dining room. Observations of the afternoon meal in the dining room on 03/23/26 at 12:20 P.M. revealed Certified Nursing Assistant (CNA) #329 was wearing medical gloves and was standing over Resident #104 feeding the resident large bites. Resident #104 repeatedly pushed CNA #329's hand away and the aide responded by pushing the resident's hands down. Resident #104 picked up a glass of juice, and when CNA attempted to remove the juice from the resident's hand, the juice spilled onto the table. CNA #329 then grimaced with anger, sighed loudly, tore her gloves off, threw the gloves onto the table in front of the resident, and then the CNA put her index finger up near the resident's face. Resident #104 hung her head and said nothing. Staff told CNA #329 to leave the dining room, and the aide walked out of the dining room. During an interview on 03/23/26 at 12:21 P.M, Licensed Practical Nurse (LPN) #920 stated she would finish assisting the resident with her meal. LPN #920 told CNA #329 to leave the dining room, but the aide was allowed to remain on the unit. Review of the facility Abuse Policy updated 09/01/25 revealed verbal abuse was defined as any use of oral, written or gestured language that included disparaging and derogatory terms to residents or families. All abuse was to be reported immediately for investigation.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on medical record review, review of facility Self-Reported Incidents (SRIs), staff interview, and review of the facility policy, the facility failed to ensure allegations of abuse were reported to the state agency in a timely manner. This affected one (Resident #21) of three residents reviewed for abuse. The facility also failed to report allegations of abuse to the state agency. This affected one (Resident #10) of three residents reviewed for abuse. The facility census was 98 residents.Findings include: 1.Review of the medical record for Resident #21 revealed an admission date of 02/10/25 with diagnoses including congestive heart failure, chronic obstructive pulmonary disease, and paroxysmal atrial fibrillation. Review of the Minimum Data Set (MDS) assessment for Resident #21 revealed the resident was cognitively intact. Record review of the facility SRI initiated 03/16/26 revealed an allegation of physical abuse in which Resident #21 reported on 03/13/26 that Registered Nurse (RN) #204 allegedly struck her ear with a towel. Interview on 03/25/26 at 4:41 PM with RN # 204 confirmed the alleged incident of abuse occurred on 03/13/26 at approximately 10:30 PM and was reported immediately to the Licensed Practical Nurse (LPN) supervisor #107. RN #204 confirmed that on 03/13/26, Resident #21 reported to LPN Supervisor #107 that RN #204 physically struck Resident #21 with a towel. Interview on 03/26/26 at 10:14 A.M. with the Director of Nursing (DON) confirmed she was first notified of Resident #21's allegation of abuse per RN #204 on 03/16/26. The DON confirmed staff were expected to report allegations of abuse immediately to their direct supervisor, and the supervisor was expected to escalate the allegation to the DON or Administrator immediately. The DON confirmed the allegation of abuse was made on 03/13/26, but the incident was not reported to her until 03/16/26 which is why the SRI was not initiated until 03/16/26. 2. Review of medical record for Resident #10 revealed an admission date of 06/16/25 with diagnoses including osteomyelitis of right ankle and foot, diabetes mellitus type two, and morbid obesity. Review of the MDS assessment for Resident #10 revealed the resident was cognitively intact and used a wheelchair for mobility. Review of the facility SRIs for October 2025 revealed there were no SRIs filed regarding Resident #10. During an interview on 03/25/26 at 6:59 A.M., the DON stated someone, she couldn't remember who, had reported to her that sometime in October 2025, she couldn't remember the date, Resident #10 alleged Certified Nursing Assistant (CNA) #351 had called Resident #10 a baby. The DON reported CNA #351 was removed from Resident #10's care but not from resident care while administration did an internal investigation. The DON confirmed CNA #351 received a disciplinary write-up related to the allegation of verbal abuse per Resident #10, but the facility had not filed an SRI. Review of the facility policy titled Reporting Abuse, Neglect, Mistreatment, Exploitation and Misappropriation of Property, dated 11/16/16, revised 06/01/25, revealed all suspected violations and all substantiated incidents of abuse will be promptly reported to appropriate state agencies and other entities or individuals as may be required by law. The policy further revealed allegations of abuse are to be reported immediately to the nursing supervisor, Director of Nursing, and Administrator.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on medical record review, review of facility Self-Reported Incidents (SRIs), review of staff witness statements, observation, staff interviews, and review of the facility policy, the facility failed to prevent possible further abuse by not removing staff from the facility during the investigation. This affected three (Residents #104, #21, and #10) of three residents reviewed for abuse. The facility census was 98 residents.Findings include: 1.Review of the medical record for Resident #104 revealed an admission date of 07/21/23 with diagnoses including essential tremors, epilepsy, Alzheimer's disease, anxiety disorder and dysphagia. Review of the Minimum Data Set (MDS) assessment for Resident #104 dated 01/02/26 revealed the resident had severe cognitive impairment and required assistance with meals. Review of the facility SRI initiated 03/23/26 and completed 03/27/26 revealed the facility's investigation determined Certified Nursing Assistant (CNA) #329 had verbally/emotionally abused Resident #104. CNA #329 was terminated from employment as a result of the abuse. Review of the SRI included review of signed witness statement per CNA #329 dated 03/23/26 which revealed the aide acknowledged she was feeding Resident #104 and when the resident spilled her drink, the aide sighed, took her gloves off, and pointed at the resident. Review of the SRI included review of a signed witness statement per LPN #920 dated 03/23/26 which revealed the Surveyor reported to LPN #104 that CNA #329 was standing over and feeding Resident #104 and the aide had taken off her gloves, thrown them on the table, and the aide pointed her finger in the resident's face. LPN #920 then sent CNA #329 out of the dining room and took over feeding Resident #104. Review of the SRI included review of a signed witness statement per LPN #108 undated revealed she was doing rounds in the facility with the Medical Director when a state Surveyor approached the MD and indicated an aide had yelled at a resident for spilling her drink. LPN #108 observed CNA #329 sitting at the desk after LPN #104 had told the aide to leave the dining room. Observations of the afternoon meal in the dining room on 03/23/26 at 12:20 P.M. revealed Certified Nursing Assistant (CNA) #329 was wearing medical gloves and was standing over Resident #104 feeding the resident large bites. Resident #104 repeatedly pushed CNA #329's hand away and the aide responded by pushing the resident's hands down. Resident #104 picked up a glass of juice, and when CNA attempted to remove the juice from the resident's hand, the juice spilled onto the table. CNA #329 then grimaced with anger, sighed loudly, tore her gloves off, threw the gloves onto the table in front of the resident, and then the CNA put her index finger up near the resident's face. Resident #104 hung her head and said nothing. Staff told CNA #329 to leave the dining room, and the aide walked out of the dining room. During an interview on 03/23/26 at 12:21 P.M, Licensed Practical Nurse (LPN) #920 stated she would finish assisting the resident with her meal. LPN #920 told CNA #329 to leave the dining room, but the aide was allowed to remain on the unit. Interview on 03/26/26 at 10:14 AM with the Director of Nursing (DON) confirmed staff members accused of abuse should not be permitted to remain in the facility while an abuse investigation was pending. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.Review of the medical record for Resident #21 revealed an admission date of 02/10/25 with diagnoses including congestive heart failure, chronic obstructive pulmonary disease, and paroxysmal atrial fibrillation. Review of the MDS assessment for Resident #21 revealed the resident was cognitively intact. Record review of the facility SRI initiated 03/16/26 revealed an allegation of physical abuse in which Resident #21 reported on 03/13/26 that Registered Nurse (RN) #204 allegedly struck her ear with a towel. Review of the facility staffing schedule dated 03/13/26 through 03/15/26 revealed RN #204 continued to be assigned to work during the time period following the allegation. Interview on 03/25/26 at 4:41 P.M. with RN # 204 confirmed the alleged incident of abuse occurred on 03/13/26 at approximately 10:30 PM and was reported immediately to the Licensed Practical Nurse (LPN) supervisor #107. RN #204 confirmed that on 03/13/26, Resident #21 reported to LPN Supervisor #107 that RN #204 had physically struck Resident #21 with a towel. Interview on 03/26/26 at 10:14 A.M. with the Director of Nursing (DON) confirmed she was first notified of Resident #21's allegation of abuse per RN #204 on 03/16/26. The DON confirmed staff were expected to report allegations of abuse immediately to their direct supervisor, and the supervisor was expected to escalate the allegation to the DON or Administrator immediately. The DON confirmed the allegation of abuse was made on 03/13/26, but the SRI was not initiated until 03/16/26 and RN #204 continued to work in the facility from 03/13/26 to 03/16/26. 3. Review of medical record for Resident #10 revealed an admission date of 06/16/25 with diagnoses including osteomyelitis of right ankle and foot, diabetes mellitus type two, and morbid obesity. Review of the MDS assessment for Resident #10 revealed the resident was cognitively intact and used a wheelchair for mobility. Review of the facility SRIs for October 2025 revealed there were no SRIs filed regarding Resident #10. During an interview on 03/25/26 at 6:59 A.M., the DON stated someone, she couldn't remember who, had reported to her that sometime in October 2025, she couldn't remember the date, Resident #10 alleged Certified Nursing Assistant (CNA) #351 had called Resident #10 a baby. The DON reported CNA #351 was removed from Resident #10's care but not from resident care while administration did an internal investigation. The DON confirmed CNA #351 received a disciplinary write-up related to the allegation of verbal abuse per Resident #10. Interview on 3/26/26 at 9:15 A.M. with the DON confirmed she was unable to locate the facility's internal investigation of verbal abuse per CNA #351 towards Resident #10 sometime in October 2025 nor did the aide's personnel file contain a disciplinary write-up related to the abuse allegation per Resident #10 against CNA. Review of the facility policy titled Reporting Abuse, Neglect, Mistreatment, Exploitation and Misappropriation of Property, 06/01/25, revealed all suspected violations and all substantiated incidents of abuse will be promptly reported to appropriate state agencies and other entities or individuals as may be required by law. The policy further revealed allegations of abuse are to be (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported immediately to the nursing supervisor, Director of Nursing, and Administrator. Review of the facility Abuse Policy updated 09/01/25 revealed all allegations of abuse were to be reported immediately for investigation. If staff are accused of abuse they should be removed from the facility during the investigation.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on medical record review, review of facility fall investigations, resident interview, and staff interview the facility failed to ensure safe resident transfers to prevent falls. This affected one (Resident #4) of three residents reviewed for accidents and hazards. Based on medical record review, observation, and staff interview, the facility failed to follow safe swallowing recommendations during mealtime. This affected one (Resident #104) of three residents reviewed for accident hazards. The facility census was 98 residents.Findings include: 1.Review of the medical record for Resident #4 revealed an admission date of 06/09/23 with diagnoses including vascular dementia, major depression, and anxiety disorder. Review of the Minimum Data Set (MDS) assessment for Resident #4 revealed the resident was cognitively intact and required the assistance of one staff with transfers. Review of the nurse progress note for Resident #4 dated 03/23/26 at 7:23 A.M. revealed the nurse was called to the resident room because the resident had fallen in the bathroom while a staff person was assisting with transferring the resident from the toilet. Review of the facility investigation for Resident #4's fall on 03/23/26 revealed staff had transferred the resident from the toilet without using a gait belt. Interview on 03/23/26 at 4:45 P.M with Resident #4 confirmed she had fallen in the bathroom earlier in the day while staff were transferring her, and the fall occurred because the staff person had not transferred her correctly. Interview on 03/26/26 at 11:30 A.M. with the Director of Nursing (DON) confirmed the facility policy was to use gait belts with all manual transfers. The DON stated the aide who transferred Resident #4 on 03/23/26 at approximately 7:23 A.M. was Certified Nursing Assistant (CNA) #329 and the aide had not used a gait belt as per policy. Review of the facility policy titled Gait Belts undated revealed staff should always have a gait belt on their person. Gait belts should be used for assisting residents with ambulation and transfers from sitting or standing. 2, Review of the medical record for Resident #104 revealed an admission date of 07/21/23 with diagnoses including essential tremors, epilepsy, Alzheimer's disease, anxiety disorder, and dysphagia. Review of the Minimum Data Set (MDS) assessment for Resident #104 dated 01/02/26 revealed the resident had severe cognitive impairment and required assistance with meals. Review of the physician's orders for Resident #104 dated March 2026 revealed the resident was receiving a mechanical soft diet. The orders specified the resident needed partial feeding assistance such as set up, cueing, sips of fluids between one to two bites, a divided plate, built-up utensils, and was not to use straws. Observation 03/26/26 at 12:45 P.M of the afternoon meal revealed Resident #104 was drinking a soda (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the use of a straw. Interview on 03/26/26 at 12:50 P.M with CNA #305 confirmed she was not aware of the resident's requirements for safe swallowing which included the residents were not to drink using a straw. Interview on 03/26/26 at 1:00 P.M with Licensed Practical Nurse (LPN) #920 confirmed Resident #104 had been drinking with a straw, but the resident had a physician's order not to drink with straws due to the resident's requirements for safe swallowing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365045	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillebrand Nursing and Rehabilitation Center	4320 Bridgetown Road Cincinnati, OH 45211

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on medical record review, observation, and staff interview, the facility failed to ensure residents had adaptive utensils at meals as ordered by the physician. This affected one (Resident #104) of 24 residents sampled. The facility census was 98 residents. Findings include: . Review of the medical record for Resident #104 revealed an admission date of 07/21/23 with diagnoses including essential tremors, epilepsy, Alzheimer's disease, anxiety disorder, and dysphagia. Review of the Minimum Data Set (MDS) assessment for Resident #104 dated 01/02/26 revealed the resident had severe cognitive impairment and required assistance with meals. Review of the physician's orders for Resident #104 dated March 2026 revealed the resident received a mechanical soft diet. The orders specified the resident needed partial feeding assistance such as set up, cueing, sips of fluids between one to two bites, divided plate and built-up utensils and no straws. Review of the dietary ticket for Resident #104 dated 03/23/26 for lunch revealed the resident was to receive built-up utensils at meals. Observation of the afternoon meal on 03/23/26 at 12:20 P.M. revealed Certified Nursing Assistant (CNA) #329 was feeding the resident using regular utensils. There were no built-up utensils available on the tray for the resident. Resident #104 reached for the food and attempted to feed herself, but CNA #329 pushed the resident's hands away and continued to feed the resident Interview on 03/23/26 at 12:30 P.M. with CNA#329 confirmed Resident #104 required total assistance with feeding and built-up utensils were not needed. Observation on 03/26/26 at 10:05 A.M. revealed CNA #558 was feeding the resident using regular utensils. CNA #558 left the resident, and then the resident attempted to feed herself some more food using the regular utensils. There were no built-up utensils available on the tray. Resident #104 appeared to have difficulty handling the regular utensils and kept dropping them. Interview on 03/26/26 at 12:45 P.M. with CNA #558 confirmed she was not aware Resident #104 had a physician's order for the use of built-up utensils. CNA #558 also stated Resident #104 was hospice and she was feeding her so the resident wouldn't make a mess.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure staff donned proper personal protective equipment (PPE) when providing gastrostomy tube (g-tube) care to residents with physician's orders for enhanced barrier precautions (EBP.) The affected one (Resident #23) of two facility-identified residents with orders for EBP. The facility census was 98 residents. Findings include: Review of the medical record for Resident #23 revealed an admission date of 08/18/25 with diagnoses including congestive heart failure, atrial fibrillation, and gastrostomy status (g-tube) status. Review of the physician's orders for Resident #23 revealed an order dated 9/17/25 for EBP due to presence of a g-tube. Observation of g-tube feeding for Resident #23 on 03/25/26 at 10:23 A.M. per Licensed Practical Nurse (LPN) #114 revealed the nurse did not don a gown prior to administration. There was a sign outside Resident #23's door indicating gloves and gowns should be worn while providing care. Interview on 03/25/26 at 10:29 A.M. with LPN #114 confirmed Resident #23 was on EBP due to the presence of a g-tube and staff were supposed to don gowns prior to tube feeding administration. LPN #114 confirmed she had not donned a gown prior to caring for Resident #23. Review of facility policy titled Enhanced Barrier Precautions dated 03/30/24 revealed EBP was indicated for residents with indwelling medical devices even if the resident was not known to be infected or colonized with a multidrug-resistant organism. Review of facility policy titled Documentation for Enteral Feeding revised April 2024 revealed EBP should be followed while managing a feeding tube.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365045	A. Building B. Wing	03/26/2026

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on medical record review and staff interview, the facility failed to ensure residents were offered pneumococcal vaccines and failed to ensure resident medical records included documentation of receipt or refusal of the vaccine. This affected two (Residents #4 and #8) of five residents reviewed for infection control. The facility census was 98 residents. Findings include: 1.Review of the medical record for Resident #4 revealed an admission date of 08/24/23 with diagnoses including vascular dementia, malignant neoplasm of bladder, and atrial fibrillation. Review of the immunization record for Resident #4 revealed it did not include documentation of administration of the pneumococcal vaccine, did not include documentation of the resident receiving the vaccine prior to admission to the facility, nor did the record include documentation of resident refusal of the vaccine. 2.Review of the medical record for Resident #8 revealed an admission date of 11/06/22 with diagnoses including end stage renal disease, nonrheumatic aortic stenosis, and diabetes mellitus type two. Review of the immunization record for Resident #8 revealed it did not include documentation of administration of the pneumococcal vaccine, did not include documentation of the resident receiving the vaccine prior to admission to the facility, nor did the record include documentation of resident refusal of the vaccine. Interview on 03/26/26 at 1:32 P.M. with the Director of Nursing (DON) confirmed residents should be offered vaccines and education regarding vaccines during their first care conference at the facility. The DON confirmed there was no documentation in Residents #4 and #8's medical records to indicate if either resident had received the pneumococcal vaccine in the past, had refused the vaccine, or if the vaccine was withheld due to medical contraindications.