STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365118	A. Building B. Wing	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jag Healthcare Mansfield	50 Blymyer Avenue Mansfield, OH 44903

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility policy, the facility failed to assure missing items were investigated and followed up on for one resident, (Resident #32), of three residents reviewed for missing items. The facility census was 57. Findings include: Record review for Resident #32 revealed an admission date of 01/13/23. Diagnosis included Alzheimer's disease with late onset. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #32 was severely cognitively impaired. Resident #32 was dependent for bed mobility, chair/bed chair transfers, and wheelchair mobility. Telephone interview on 06/24/25 at 10:07 A.M. with Resident #32's family member revealed Resident #32 was missing blankets, clothing items, and stuffed animals. Resident #32's family member revealed it had been a while, between a month or two but they did let the staff know. Resident #32's family member revealed they could not remember the staff names. Interview on 06/25/25 at 9:25 A.M. with Social Worker Designee (SWD) #305 revealed she had not received any resident concerns or grievances since February 2025. SWD #305 revealed if a family or resident had a concern or grievance, they would fill out a concern log located at the front desk or a staff member could fill one out for them. If it was for missing laundry or items, she would look for the item then if she could not find it she would notify the Administrator and she would take over from there. SWD #305 revealed she never had a concern log for any missing items from Resident #32 or the family. Observation with SWD #305 revealed there were no concern logs located at the front desk. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/26/25 at 10:46 A.M. with Laundry/Housekeeping Assistant #253 revealed the laundry department gets reports of missing clothing, all the time, at least three times a week. Laundry/Housekeeping Assistant #253 revealed that sometimes families, staff or residents just come tell the laundry department what is missing but most the time they give us something in writing, usually on plain white or scrap paper or we just write it on paper. Laundry/Housekeeping Assistant #253 revealed she does not keep the notes or papers with missing items, once she looks for the item, if she cannot find it, she tells the nurse and throws the paper away and that's it. Laundry/Housekeeping observation completed with Laundry/Housekeeping Assistant #253 of the laundry room revealed two racks of clothes hanging and three full large boxes of clothing items and slippers. Laundry/Housekeeping Assistant #253 revealed these were no name items and laundry did not know who they belonged to. Interview on 06/26/25 between 11:07 A.M. and 2:01 P.M. with Certified Nursing Assistant (CNA) #227 and #231 revealed they both frequently worked with Resident #32. CNA #231 revealed, About two months ago, the family said she was missing stuffed animals but there was another resident at the facility who would wander and take stuff but I don't know what ever happened with it. CNA #227 and #231 revealed when residents or families report missing items, they go to the laundry to look for it and if they cannot find it, they tell whoever is working in laundry to keep an eye out for it. Interview on 06/26/25 at 2:06 P.M. during Resident Council meeting with nine participants, Resident #3, #14, #15, #17, #22, #28, #37, #46, and #161 all confirmed verbally or with a head nod that they each had missing clothing items and this was considered by them a big problem. Resident #37 revealed they tell the laundry lady, she always says she will look into it but they never come back to follow up about the missing clothing items. Multiple residents stated out loud simultaneously they agreed with that statement and reiterated they felt it was a big problem. Resident #17 revealed twice a year they bring out all the clothes and put them in the activities room for residents to go through to see if any of their missing clothing is in there. Review of the Resident Council Meeting minutes dated 04/30/25 revealed room [ROOM NUMBER] was missing an Ohio State short sleeve shirt and woman's jean shorts. room [ROOM NUMBER] has been missing XXXL black shorts since last summer; Residents are complaining they are not getting socks back. Review of the Resident Council Minutes review dated 04/30/25 to Department Housekeeping/laundry revealed Plans of Corrections: Housekeeping was informed to look for residents missing items and follow up upon returning resident items to ensure needs were met. Administrator signed and dated 05/07/25. No follow up was documented as to finding or not finding the missing items or follow up with the residents. Review of the Resident Council Meeting minutes dated 05/28/25 revealed room [ROOM NUMBER] received clothes that did not belong to her. Review of the facility policy titled, Grievances/Complaints, Recording and Investigating undated revealed all grievances and complaints filed with the facility will be investigated and corrective action will be taken to resolve the grievances. The Grievance Officer will record and maintain all grievances and complaints on the Grievance Report. The following information will be recorded and maintained in the log: a. The date the grievance/complaint received. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. The name and room number of the resident filing the grievance/complaint. c. The name and relationship of the person filing the grievance/complaint on behalf of the resident. d. The date the alleged incident took place. e. The name of the person investigating the incident. f. The date the resident or interested party was informed of the findings. g. The disposition of the grievance. h. The grievance/complaint form will be filed with the Administrator within five working days of the incident. This deficiency represents non-compliance investigated under Complaint Number OH00166248.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Review of the medical record for Resident #110 revealed an admission date of 06/13/25. Diagnoses included chronic pain, hemiplegia and hemiparesis, cerebral infarction, hypertension, atrial fibrillation, congestive heart failure, and narcissistic personality disorder. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. Review of a wound assessment report dated 06/20/25 revealed the resident had bilateral lower extremity venous ulcers. Review of a physician order dated 06/21/25 revealed to cleanse the bilateral lower extremities with wound cleanser, pat dry, apply ammonium lactate lotion to both lower legs topically, apply non-adhering dressing then a dry dressing over wounds, cover with an elastic tubular bandage and then wrap with and outer elastic bandage daily and as needed for venous ulcer wound care. Observation on 06/23/25 at 12:30 P.M. revealed Resident #110 had elastic bandages covering his bilateral lower extremities from below the knees to the top of the feet. Further observation revealed the wound dressings were not dated. Interview on 06/23/25 at 12:30 P.M., Resident #110 revealed his wound dressings had not been changed since 06/20/25 when the wound nurse assessed and changed the dressings. Resident #110 stated the staff never dated his wound dressings. Observation on 06/24/25 at 1:32 P.M., Licensed Practical Nurse (LPN) #259 verified Resident #100's wound dressings to the bilateral lower extremities were not dated. Further observation of wound care revealed LPN #259 removed the elastic cover bandage covering the wounds revealing the inner tubular elastic bandage, abdominal pad, and non-adherent were saturated with dried drainage on each lower extremity. LPN #259 applied new wound care dressings per physician orders. LPN #259 had not dated the wound dressings. Interview on 06/25/25 at 2:12 P.M., LPN #259 revealed the wound dressing appeared to not have been changed recently due to the amount of saturation of the dressings. LPN #259 verified she had not dated the residents wound care dressings to the bilateral lower extremities. Interview on 06/25/25 at 9:34 A.M., LPN #275 verified also not dating wound dressings for Resident #110. Further interview with LPN #275 revealed completing the resident's wound care dressing changes on 06/21/25. Review of the Treatment Administration Record (TAR) dated 06/21/25 through 06/24/25 revealed no documentation the resident's wound dressing to the bilateral lower extremities had been completed on 06/23/25. Interview on 06/26/25 at 11:47 A.M., the Director of Nursing (DON) verified Resident #110's wound treatment was not completed on 06/23/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the undated facility policy Wound Care revealed staff would administer wound care treatments per physician orders and date, time, and initial wound care dressings when completed. 3. Review of the medical record for Resident #27 revealed an admission date of 01/17/25. Diagnoses included chronic obstructive pulmonary disease, malignant neoplasm of colon, type two diabetes mellitus, peripheral vascular disease, acquired absence of right leg above knee, cerebral infarction, and dementia. Review of the quarterly MDS assessment dated [DATE] revealed the resident had severe cognitive impairment. Review of the care plan dated 04/22/25 revealed the resident had a left heel wound. Interventions included a weekly skin assessment for and provide treatment per physician order. Review of a skin/wound progress note dated 05/19/25 at 11:46 A.M. revealed a nursing assistant reported resident sock sticking to foot. Nurse assessed and found a new open area to the left heel measuring approximately three centimeters (cm) by two centimeters with light bleeding and serous drainage. The physician was notified, and a treatment was applied. Review of weekly skin/wound assessments revealed the wound was assessed on 05/27/25. Review of a progress note dated 05/30/25 at 12:47 P.M. revealed the wound nurse practitioner noted the resident had a diabetic foot ulcer to the left lateral foot measuring 2.4 cm in length by three cm in width by 0.1 cm in depth with moderate serous drainage. New wound care orders included to cleanse with wound cleanser, apply calcium alginate with silver to base of wound and secure with bordered foam daily and as needed. Also to float heels while in bed with the use of heel boots. Review of a weekly skin/wound assessment dated [DATE] revealed no assessment of the resident's left heel was completed. Further review of the weekly skin/wound assessments revealed no further weekly wound assessments had been completed since 05/30/25. The resident had appointments at an outside wound care provider on 06/05/25 and 06/19/25 with no wound measurements provided. Observation on 06/24/25 at 2:21 P.M., of wound care for Resident #27 with Licensed Practical Nurse (LPN) #259 revealed a wound on the left posterior heel with discoloration approximately 2.5 centimeters in length and 1.5 cm in width with no depth as the skin was intact. There was no drainage or signs of infection. Interview on 06/30/25 at 1:51 P.M., the Director of Nursing (DON) confirmed there was no documentation of weekly wound assessments completed for Resident #27 since 05/30/25. The DON revealed nursing staff should be completing weekly wound evaluations to monitor, measure, and assess the wound. Review of the undated facility policy Wound Care, revealed no guidelines for the frequency of wound assessments. Further review of the policy revealed to document wound assessment data (wound bed color, size, drainage) obtained when inspecting the wound. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, record review, and review of the facility policy, the facility/ Hospice Registered Nurse (RN) failed to assure Resident #160 received pain medications when she expressed she was having pain throughout the procedure of an indwelling catheter reinsertion and peri care and the facility failed to address a change in condition timely for Resident #160 when her peri area, buttocks, and under her bilateral breast were observed by facility staff and Hospice RN to be deep red. Additionally the facility failed to ensure wound care was provided and timely complete wound assessments were completed for two (#110, #27) of three residents reviewed for wound care. The facility identified seven residents with non-pressure wounds. The facility census was 57. Findings include: 1. Record review for Resident #160 revealed an admission date of 05/28/25. Diagnoses included heart failure, obesity, Diabetes Mellitus with diabetic polyneuropathy, and low back pain. Resident #160 received hospice services. Review of the admission Minimum Data Set (MDS) dated [DATE] for Resident #160 revealed Resident #160 was moderately cognitively impaired. Resident #160 required partial/moderate assistants with eating and was dependent for toileting hygiene, bathing and bed mobility. Resident #160 had an indwelling catheter and was occasionally incontinent of bowel. Resident #160 occasionally had pain and received scheduled and as needed (PRN) pain medications. Review of the care plan dated 06/23/25 revealed Resident #160 was at risk for infection and/or trauma related to use of foley catheter, neurogenic bladder. Interventions included to check for patency and urinary output every shift; Monitor for signs and symptoms of urinary tract infection (UTI): burning on urination, flank pain, hematuria, decreased urinary output, change in mental status, change in behavior, fever, change in color, clarity and/or odor of urine. Review of the physician orders for Resident #160 revealed an order dated 05/29/25 to keep foley diagnosis is oliguria. An additional order revised 05/30/25 revealed keep foley catheter 16 french 10 milliliter (ml) balloon diagnosis is oliguria. A revised order dated 06/19/25 revealed keep foley catheter 16 french 10 milliliter (ml) balloon diagnosis is neurogenic bladder. Review of the physician orders revealed orders dated 05/30/25 for Morphine Sulfate (opioid) oral solution 20 mg/ml give 10 mg by mouth every six hours for pain and 10 mg by mouth every one hour as needed for pain or shortness of breath. Review of the physician orders for Resident #160 revealed an order dated 05/30/25 revealed an order for Enhanced Barrier Precautions (EBP) due to foley catheter every day and night shift. Observation on 06/23/25 at 10:08 A.M. revealed Resident #160 was lying in bed. Resident #160's husband was present and revealed he just arrived to visit with Resident #160. Resident #160 had no top or pants on and was completely uncovered. Resident #160 was scratching at her peri area aggressively. The brief Resident #160 was wearing had been saturated with a red substance. Resident #160 was not responding to questions and continued scratching. Resident #160's husband placed Resident #160's call light on. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/23/25 at 10:10 A.M. revealed Certified Nursing Assistant (CNA) #280 entered Resident #160's room. CNA #280 confirmed Resident #160 had blood inside her brief saturating the center peri area of the brief. CNA #280 turned Resident #160 to her side. A moderate amount of blood was observed on the pad under Resident #160. The indwelling catheter was lying on the mattress next to Resident #160 with a fully inflated balloon. The catheter had blood on the tubing and balloon. At 10:11 A.M. CNA #226 entered the room and assisted CNA #280 with peri care. Multiple old and new scratches were observed on Resident #160's thighs. CNA #226 revealed some of the scratches were older and some were new. There was blood with blood clots inside Resident #160's brief that CNA #226 and #280 removed. At 10:26 A.M. Registered Nurse (RN) #299 entered the doorway of the room. RN #299 did not observe or assess Resident #160, RN #299 stood in the doorway and revealed she will come in and replace the indwelling catheter when her medication pass was completed. RN #299 then exited the room. Observation after peri care was completed revealed Resident #160's vaginal area was deep red, under bilateral breasts were deep red and the buttocks/peri area was deep red. Interview on 06/23/25 at 10:45 A.M. with RN #299 revealed when asked if she was going to replace Resident #160's indwelling catheter, She is hospice so, I am going on break right now. Interview on 06/23/25 at 1:09 P.M. with Hospice #320's Hospice RN #321 revealed Resident #160 had an indwelling catheter due to urinary retention. Hospice RN #321 revealed Resident #160 never removed her indwelling catheter prior to today. Observation revealed Hospice RN #321 placed a pair of clean disposable gloves on. Hospice RN #321 did not wash her hands prior to placing the clean gloves on. Hospice RN then place a pair of sterile gloves over the clean gloves. Hospice RN #321 then attempted to insert the indwelling catheter into Resident #160's urethra with no assistants. Resident #160 was morbidly obese and was not following direction. Hospice RN #321 then attempted several times inserting the catheter into the urethra which was not visible due to positioning. Resident #160 repeatedly yelled out., ow, ow ,ow during the entire procedure of attempting to place the indwelling catheter into the urethra. Hospice RN #321 then inserted the catheter in the area, pushed 30 milliliters (ml) of fluid in the catheter balloon while Resident #160 continued yelling out, ow, ow, ow. Hospice RN #321 confirmed Resident #160's was very red inside her vaginal area and under her breast. Hospice RN #321 also confirmed Resident #160 was having pain during the procedure and confirmed she never offered any as needed pain medication before or during the procedure. Per Hospice RN #321, Resident #160 had as need pain medication available for use if needed. Hospice RN #321 revealed Resident #160 was incontinent of urine on her brief. Hospice RN #321 turned Resident #160 to her right side. Resident #160's buttocks was deep red, Hospice RN #321 pulled Resident #160's brief from under her ripping the brief into several pieces as she kept pulling on it grabbing different areas of the brief. Surveyor suggested waiting for assistants to continue with the care. At 1:28 P.M. Licensed Practical Nurse (LPN) #261 entered the room to assist. Observation revealed the indwelling catheter came out. Hospice RN #321 revealed it fell out because it was not in the right area. Observation revealed during peri care provided by Hospice RN and LPN #261, Resident #160 continued to yell out, ow, ow, ow every time her vaginal area was touched. Hospice RN #321 never offered pain medication. Hospice RN #321 confirmed she never offered Resident #160 any pain medication although Resident #160 repeatedly yelled out in pain throughout the procedure, and confirmed Resident #160 had as needed pain medication available. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/24/25 at 1:35 P.M. with RN #299 revealed the Hospice nurse never told her about the red areas in the vaginal area, buttocks or under the breast and confirmed Resident #160 never received orders to treat the areas. RN #299 revealed she will call hospice for new orders. RN #299 confirmed she never attempted to replace Resident #160's indwelling catheter on this day either, she was waiting for Hospice. Review of the physician order for Resident #160 revealed an order dated 06/24/25 for Diflucon 200 mg by mouth for yeast for five days until finished.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review revealed the facility failed to ensure an indwelling catheter for one resident, Resident #160 was addressed timely to include a physical assessment and reinsertion when Resident #160 removed the catheter. The facility also failed to notify the primary care physician of the catheter and failed to notify the primary care physician and Hospice provider of the results of a urinalysis timely that resulted in bacterial growth requiring treatment of an antibiotic. This affected one resident, Resident #160 and had the potential to affect an additional seven residents, Resident #5, #26, #35, #36, #40, #43, and #50 identified by the facility as having indwelling catheters. The facility census was 57. Findings include: Record review for Resident #160 revealed an admission date of 05/28/25. Diagnoses included heart failure, Absence of right and left leg below the knee, obesity, diabetes mellitus with diabetic polyneuropathy, and low back pain. Resident #160 received hospice services. Review of the admission Minimum Data Set (MDS) dated [DATE] for Resident #160 revealed Resident #160 was moderately cognitively impaired. Resident #160 was dependent for toileting hygiene, bathing and bed mobility. Resident #160 had an indwelling catheter and was occasionally incontinent of bowel. Review of the care plan dated 06/23/25 revealed Resident #160 was at risk for infection and/or trauma related to use of foley catheter, neurogenic bladder. Interventions included to check for patency and urinary output every shift; Monitor for signs and symptoms of urinary tract infection (UTI): burning on urination, flank pain, hematuria, decreased urinary output, change in mental status, change in behavior, fever, change in color, clarity and/or odor of urine. Review of the physician orders for Resident #160 revealed an order dated 05/29/25 to keep foley diagnosis is oliguria. An additional order revised 05/30/25 revealed keep foley catheter 16 french 10 milliliter (ml) balloon diagnosis is oliguria. A revised order dated 06/19/25 revealed keep foley catheter 16 french 10 milliliter (ml) balloon diagnosis is neurogenic bladder. Review of the Nursing Progress Note for Resident #160 dated 06/15/25 at 2:08 A.M. included Resident #160 complained of urgency stating she felt like she had to pee. Increased agitation and confusion. Urine in catheter bag was cloudy and had a strong odor. The note included would speak with hospice for a urine analysis culture and sensitivity (UA C&S) laboratory test Review of the Nursing Progress Note for Resident #160 dated 06/16/25 at 11:59 A.M. revealed Certified Nursing Assistant (CNA) reported urine had a foul odor. Resident educated to consume more water due to strong urine. Review of the Nursing Progress Note for Resident #160 dated 06/18/25 at 9:24 A.M. revealed a call was placed to hospice to obtain a urine sample to send to lab for a UA C&S due to cloudy urine and a strong urine smell and increased confusion. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician orders for Resident #160 revealed an order dated 06/18/25 revealed an order to collect urine for a urinalysis, culture and sensitivity to be sent to laboratory and notify hospice of results. Review of the Nursing Progress Note for Resident #160 dated 06/19/25 at 6:09 A.M. revealed urine collected from resident this A.M. and sent to lab for a UA C&S. Review of the Nursing Progress Notes for Resident #160 from 06/19/25 through 06/24/25 at 2:00 P.M. revealed no further documentation, results or orders from UA or C&S obtained 06/19/25. Observation on 06/23/25 at 10:08 A.M. revealed Resident #160 was lying in bed. Resident #160's husband was present and revealed he just arrived to visit with Resident #160. Resident #160 had no top or pants on and was completely uncovered. Resident #160 was scratching at her peri area aggressively. The brief Resident #160 was wearing had been saturated with a red substance. Resident #160 was not responding to questions and continued scratching. Resident #160's husband placed Resident #160's call light on. Observation on 06/23/25 at 10:10 A.M. revealed Certified Nursing Assistant (CNA) #280 entered Resident #160's room. CNA #280 confirmed Resident #160 had blood inside her brief saturating the center peri area of the brief. CNA #280 turned Resident #160 to her side. A moderate amount of blood was observed on the pad under Resident #160. The indwelling catheter was lying on the mattress next to Resident #160 with a fully inflated balloon. The catheter had blood on the tubing and balloon. At 10:11 A.M. CNA #226 entered the room and assisted CNA #280 with peri care. CNA #226 revealed Resident #160 was last changed at 6:00 A.M.; There was blood with blood clots inside Resident #160's brief that CNA #226 and #280 removed. At 10:26 A.M. Registered Nurse (RN) #299 entered the doorway of the room. RN #299 did not observe or assess Resident #160, RN #299 stood in the doorway and revealed she will come in and replace the indwelling catheter when her medication pass was completed. RN #299 then exited the room. Interview on 06/23/25 at 10:45 A.M. with RN #299 revealed when asked if she was going to replace Resident #160's indwelling catheter, She is hospice so, I am going on break right now. Interview on 06/23/25 at 12:14 P.M. with RN #299 revealed the hospice nurse never came yet and she would let the surveyor know when the hospice nurse comes to replace Resident #160's indwelling catheter. (continued on next page)

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	365118	A. Building B. Wing	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jag Healthcare Mansfield	50 Blymyer Avenue Mansfield, OH 44903

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/23/25 at 1:09 P.M. with Hospice #320's, Hospice RN #321 revealed Resident #160 had an indwelling catheter due to urinary retention. Hospice RN #321 revealed Resident #160 never removed her indwelling catheter prior to today. Observation revealed Hospice RN #321 placed a pair of clean disposable gloves on. Hospice RN #321 did not wash her hands prior to placing the clean gloves on. Hospice RN then place a pair of sterile gloves over the clean gloves. Hospice RN #321 never placed an isolation gown on. Hospice RN #321 then attempted to insert the indwelling catheter into Resident #160's urethra with no assistance. Resident #160 was morbidly obese and was not following direction. Observation revealed Hospice RN was attempting to hold the catheter in one hand, spread Resident #160's legs with her arms while trying to separate the labia with the second hand to visualize the urethra. Hospice RN #321 then attempted several times inserting the catheter into the urethra which was not visible due to positioning. Hospice RN #321 then inserted the catheter in the area with no urine return observed, pushed 30 milliliters (ml) of fluid in the catheter . Hospice RN #321 confirmed there was no urine return. At 1:28 PM Licensed Practical Nurse (LPN) #261 entered the room to assist. LPN #261 never placed an isolation gown on. Observation revealed the indwelling catheter came out. Hospice RN #321 revealed it fell out because it was not in the right area. LPN #261 revealed she would look to see if the facility had another indwelling catheter for Resident #160. Interview on 06/23/25 at 2:04 P.M. with RN #299 confirmed she did not place Resident #160's indwelling catheter in stating, I did not change the catheter myself because I was busy, there are only two nurses., use to be three, now two nurses for all residents, there's not enough time. Observation on 06/24/25 at 1:35 P.M. revealed Resident #160 was lying in bed. Resident #160 did not have an indwelling catheter. Interview with RN #299 revealed Resident #160 had the catheter replaced on 06/23/24 by the hospice nurse then Resident #160 pulled it out again last night. RN #299 revealed Hospice was called this A.M., they said they will notify Resident #160's case worker and will call back. RN #299 revealed Hospice never called back yet and confirmed Resident #160's primary physician was never notified of the catheter coming out. RN #299 revealed, Most hospice companies take care of everything so we just notify hospice. RN #299 revealed she will call hospice for new orders. RN #299 confirmed she never attempted to replace Resident #160's indwelling catheter on this day either, she was waiting for Hospice. Interview 06/24/25 1:47 P.M. with Director of Nursing (DON) revealed an acceptable amount of time to wait to assess a resident when a resident has a change in condition such as an indwelling catheter coming out would be immediate. The nurse should stop what they are doing and assess the resident including any trauma to the area from the catheter being pulled out. The facility nurse should address the concern, replace the catheter then update hospice and the primary physician. Record review for Resident #160 revealed the UA C&S results for the urine obtained 06/19/25 were not available in the medical records and there was no further documentation after the urine was obtained regarding the urinalysis results. Interview with DON on 06/24/25 at 3:30 P.M. confirmed Resident #160 did not have the UA obtained on 06/19/25 or C&S results in the medical record and no follow up on the results were documented. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/24/25 at 4:45 P.M. with DON revealed she called the lab and obtained the results of the UA C&S for Resident #160. Review of the lab results revealed the results were faxed to the facility on [DATE] at 4:20 P.M.; Resident #160 had greater than 100,000 growths of both Escherichia coli and pseudomonas aeruginosa. DON revealed the lab said they just got the results and never sent a preliminary. Interview on 06/24/25 at 4:57 P.M. with Resident #160's husband revealed he noticed a huge change in his wife about two weeks ago and revealed she was sluggish, more confused, not herself. Review of the physician order for Resident #160 revealed an order was written on 06/24/25 for Cipro (antibiotic) 250 mg give one tablet orally two times a day for urinary tract infection (UTI) for seven days. Telephone interview on 06/25/25 at 10:04 A.M. with Laboratory Director #324 revealed Resident #160's urinalysis was obtained from the facility on 06/19/25 at 2:00 A.M.; The urinalysis result were reported faxed to the facility on [DATE] at 7:33 A.M. The C&S was completed on 06/21/25 at 8:55 A.M. but not faxed until 06/24/25. Lab Director #324 revealed when a urinalysis is completed that required a C&S, the urinalysis is sent to a different location for the C&S. The staff that completed the urinalysis at the first lab for Resident #160 did not put the fax request in so that the second lab who completed the C&S was aware to fax the results to the facility. Some facilities have electronic access to obtain results immediately and some prefer to be faxed. The lab does not know unless it is written on the request that they need to fax it. Lab Director #324 confirmed the C&S result would not have been sent to the facility if they did not call to request it on 06/24/25. Review of the lab confirmation sent via e-mail from Laboratory Director #324 confirmed the abnormal urinalysis report for Resident #160 was successfully sent via fax to the facility on [DATE] at 11:20 A.M.; The C&S was sent via fax to the facility on [DATE] successfully at 4:33 P.M. Interview on 06/25/25 at 3:20 P.M. with DON confirmed the facility should have followed up on the lab results for the urinalysis and the C&S for Resident #160 and the nurses should have notified the hospice and physician when they received the results. This deficiency represents non-compliance investigated under Complaint Number OH00166248.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Review of the medical record for Resident #56 revealed an admission date of 04/07/25 and a discharge date of 06/02/25. Diagnoses included pneumonia, acute respiratory failure with hypoxia, heart failure, hypertension, chronic obstructive pulmonary disease, and Alzheimer's disease. Review of the admission Minimum Data Set (MDS) dated [DATE] revealed the resident had moderate cognitive impairment. Review of the physician orders dated 04/08/25 revealed an order for Lasix 20 milligrams, one tablet by mouth every 24 hours as needed for edema or greater than three-pound weight gain in 24 hours, weigh daily in the morning, if greater than three-pound weight gain, give the as needed Lasix. Review of the Medication Administration Record (MAR) dated 05/01/25 through 06/02/25 revealed Resident #56 was not weighed per physician orders on 05/01/25, 05/12/25, 05/13/25, 05/16/25, 05/17/25, 05/18/25, 05/20/25, 05/21/25, 05/22/25, 05/26/25, 05/27/25, and 05/30/25. Further review of the MAR revealed on 05/03/25 the resident weighed 98.5 pounds and on 05/04/25 the resident weighed 103.6 pounds. On 05/25/25 the resident weighed 102.6 pounds, and no weights were completed on 05/26/25 and 05/27/25. On 05/28/25 the resident weighed 109 pounds. Continued review of the MAR revealed the resident was not administered the as needed Lasix for the greater than three-pound weight gains on 05/04/25 and 05/28/25. Interview on 06/26/25 at 12:05 P.M., the Director of Nursing (DON) verified Resident #56's weights were not obtained per physician orders, and the resident was not administered Lasix per physician orders for greater than three-pound weight gains. Review of the undated facility policy Administering Medications revealed medications would be administered in a safe and timely manner, and as prescribed, including any required time frame. This deficiency represents noncompliance investigated during Complaint Number OH00166248. Based on medical record review, staff interview, and facility policy review, the facility failed to ensure residents remained free from significant medications errors. This affected two (#161, #56) of six residents reviewed for medication administration. This had the potential to affect an additional 11 residents (#3, #8, #11, #12, #14, #16, #27, #28, #30, #43, and #57) who received insulin via insulin pen. The facility census was 57. Findings include: 1. Review of Resident #161's medical record revealed an admission date of 05/28/25. Diagnoses include type two diabetes mellitus, major depressive disorder, and iron deficiency anemia. Review of the admission MDS assessment dated [DATE] revealed the resident had moderate cognitive impairment. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #161's physician orders revealed an order for Humalog 100 unit/milliliter (ml). Inject 16 units subcutaneously before meals for diabetes related to type two diabetes mellitus. Also included in the physician's orders was a sliding scale insulin order for blood sugar regulation. Observation on 06/25/25 at 10:59 A.M. revealed Registered Nurse (RN) #300 obtained the blood glucose level of 293 for Resident #161. Per the physician's orders and sliding scale, RN #300 stated he would administer 22 units of insulin. Observation on 06/25/25 at 11:00 A.M. of RN #300 administering insulin revealed RN #300 had not primed the insulin pen prior to administering the 22 units of insulin. Concurrent interview with RN #300 verified he should have primed the insulin pen prior to administration. Review of the manufacturers instructions for a Humalog insulin pen revealed to prime the pen, turn the dose knob to select 2 units. Holding the pen with the needle pointing up, tap the cartridge holder gently to collect air bubbles at the top. Eject the two units of insulin and hold the dose knob until you see insulin at the tip of the needle. Review of the undated policy titled Insulin Administration Purpose revealed nursing staff have access to manufacturer instructions.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on review of Quality Assessment and Assurance (QAA) meeting sign-in documentation, staff interview, and facility policy review, the facility failed to have required Quality Assessment and Assurance quarterly meetings with required members. This had the potential to affect all residents. The facility census was 57. Findings include: Review of the QAA sign in sheets revealed the facility had no documentation of QAA meetings for the first, second, and third quarters of 2024. The facility allowed viewing of fourth quarter QAA meeting documentation for 12/17/24 but there was no sign-in sheet for required members. Further review of the QAA sign-in sheets revealed the facility had a QAA meeting on 01/31/25 not attended by the Medical Director and another meeting on 02/28/25 not attended by the Director of Nursing or Infection Preventionist. Interview on 07/01/25 at 8:53 A.M. with the Administrator verified the facility had no documentation of quarterly QAA meetings prior the fourth quarter of 2024. The Administrator revealed the building was under new ownership beginning 11/01/24. The Administrator verified there was no documentation all required members were present during the 12/2024 fourth quarter meeting. Further interview with the Administrator revealed required members were not all present together for a QAA meeting for the first quarter of 2025. Review of the undated policy titled Quality Assurance and Performance Improvement (QAPI) Program - Governance and Leadership revealed the following individuals serve on the committee: administrator, or a designee who is in a leadership role, director of nursing services, medical director, infection preventionist, and representatives of the following departments as requested by the administrator: pharmacy, social services, activity services, environmental services, human resources, and medical records. The committee would meet at least quarterly.