STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365134	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hickory Ridge Nursing & Rehabilitation Center	721 Hickory St Akron, OH 44303

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews, observations, interviews, personnel file review, and employee handbook review, the facility failed to ensure resident respect and dignity was maintained when Certified Nursing Assistants (CNA) acted in an unprofessional manner while working in the facility. This affected two residents (Resident #01 and #85) out of eight residents reviewed for abuse. The facility census was 141.Findings include:Review of the medical record for Resident #85 revealed admission date of 08/25/22 with diagnoses including, but not limited to, unspecified dementia, alcohol dependence with alcohol-induced dementia, vascular dementia, anxiety, depression, insomnia, encephalopathy, and unspecified psychosis. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #85 had a Brief Interview Mental Status (BIMS) score of 09 indicating impaired cognition. The assessment indicated he could adequately hear, had clear speech, understood others, and had no behaviors noted. Review of Resident #85's care plan dated 09/26/22 for mood/behaviors revealed Resident #85 can refuse care at times and repetitively ask the same questions requiring assistance and cuing to perform activities of daily living (ADL). Review of the medical record for Resident #01 revealed admission date on 03/10/22 with diagnoses including, but not limited to, unspecified mood disorder, anxiety, post-traumatic stress disorder, and depression. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #01 had a Brief Interview Mental Status (BIMS) score of 15 indicating intact cognition. The assessment indicated he could adequately hear, had clear speech, understood others, and had no behaviors noted. Review of Self-Reported Incident (SRI) #269286 from the facility on 01/01/26 revealed CNA #413 made inappropriate comments to Resident #85. The staff member was suspended but had no previous disciplinary actions. A head-to-toe assessment was completed with no negative findings. Resident #85 denied any physical contact with CNA #413. His guardian and doctor were notified of the incident. Interviews conducted with residents with BIMS of 09 or greater completed with no additional concerns identified. Assessments of residents with BIMS of less than 09 completed with no significant findings. Interviews with staff revealed no concerns. The staff was re-educated on the abuse policy. Review of the witness statement from CNA #413 on 01/01/26 revealed Resident #85 was extremely agitated most of the day. CNA #413 denied making any other derogatory statements to Resident #85 or any other residents. This statement was taken by the Administrator and originally had CNA #413 ' s first name with an incorrect last name. (continued on next page)

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	Review of the witness statement taken by the Administrator on 01/01/26 from Resident #01 (Resident #85 ' s roommate) for SRI #269286 revealed he had not heard any inappropriate statements and was only aware of the situation because Resident #85 had told him. Review of a hand-written witness statement by Licensed Practical Nurse (LPN) #392, dated 01/01/26, revealed she was sitting in the conference room having lunch and heard a loud commotion coming from the smoking area. LPN #392 went to investigate and saw CNA #413 standing in the doorway passing out cigarettes and screaming profanities. It was unclear who CNA #413 was yelling at. She stated the situation then settled down. LPN #392 did not hear her making specific threats toward any patients, only cursing. Review of a typed witness statement by LPN #392, dated 01/01/26, revealed she was sitting in the conference room with several staff having lunch when there was a commotion coming from the smoking area. Resident #85 was agitated yelling out. LPN #392 did not hear CNA #413 making any specific threats toward any residents. Review of a witness statement by LPN #386, dated 01/01/26, observed CNA #413 cursing and yelling near the common lounge area. CNA #413 was sent home by the supervisor for her behavior. Interview on 01/08/26 at 9:28 A.M. with Resident #85 revealed CNA #413 was very inappropriate and always mean to people. He stated during the smoke break on 01/01/26, CNA #413 stated to him that he had a very small dick and her husband ' s was bigger. Resident #85 stated she was swearing at him. Resident #85 indicated his roommate (Resident #01) overheard the statements made because he was right next to him during the smoke break. He stated there were no other staff present. Interview on 01/08/26 at 9:30 AM with Resident #01 revealed CNA #413 made inappropriate comments to Resident #85 including the size of his penis and was using profanities at him. Resident #01 indicated the comments were made at smoking break and no other staff were present. Interview on 01/08/26 at 9:39 A.M. with the Director of Nursing (DON) revealed CNA #413 was no longer employed by the facility but she was unsure why she was terminated. Interview on 01/08/26 at 10:14 A.M. with the DON revealed CNA #413 was terminated due to her lack of professionalism. Previously CNA #413 had disciplinary action for professionalism so she was terminated due to this being her second offense. Interview on 01/08/26 at 1:46 P.M. with the Human Resources (HR) Director #370 indicated the DON was given the witness statements related to CNA #413 ' s termination. Observation and interview on 01/08/26 at 1:49 P.M. of the HR Director #370 speaking with the DON revealed the HR Director #370 revealed she had given the witness statements to the DON by placing them in her mailbox the previous day. The DON indicated the witness statements were given to Regional Director #503. Interview on 01/08/26 at 2:26 P.M. with CNA #348 revealed on 01/01/26 there was a commotion at the smoking door. She stated she had observed CNA #413 and two residents arguing. CNA #348 was unsure why CNA #413 was not sent home immediately after, but she did not leave the facility until 3:00 P.M. CNA #348 indicated the facility was short-staffed that day. CNA #348 indicated CNA #413 had been observed treating residents without respect and dignity in the past. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/12/26 at 10:54 A.M. with the Administrator revealed when Resident #01 was interviewed the verbiage used was Resident #85 told Resident #01 about the situation. The Administrator stated it was a he said, she said situation. She stated she had never asked Resident #01 if he was present during the incident between Resident #85 and CNA #413. The Administrator indicated Resident #01 was cognitively intact. Interview on 01/12/26 at 10:54 A.M. with the Administrator verified it was documented on the SRI that CNA #413 had no previous disciplinary actions. After review with her with CNA #413 ' s employee file, she verified CNA #413 had a previous disciplinary action in her employee file dated 05/02/25 for arguing with another employee at the nurse ' s station and yelling on the floor. The Administrator indicated the reason it was documented on the SRI that way was due to CNA #413 not having disciplinary actions toward residents or their care. The Administrator revealed CNA #413 was not terminated due to the SRI allegation but due to her unprofessional behavior and profanities she was yelling at the smoking area. Interview on 01/12/26 at 11:14 A.M. with Regional Director #503 revealed CNA #413 was having a bad day, acting inappropriately, and was sent home early on 01/01/26. She stated that CNA #413 was displaying behaviors that the company would not tolerate so she was terminated. Regional Director #503 denied CNA #413 making any derogatory comments to Resident #85 but did admit to using profanities while on duty. Interview on 01/12/26 at 2:40 P.M. with LPN #384 revealed she was the charge nurse that weekend. LPN #384 revealed she was in the conference room eating and heard CNA #413 using profanities. She indicated there were residents out in the smoking area as it was smoke break. She stated she cannot remember which residents were in the smoking area, but it was multiple residents and were the normal smokers. LPN #384 revealed she could not hear who CNA #413 was specifically cursing at but when they arrived at the smoking door, CNA #413 calmed down. Interview on 01/12/26 at 2:44 P.M with LPN #386 revealed he was present in the facility on 01/01/25. LPN #386 indicated he was eating in the conference room when he heard a commotion from the smoking area. He stated CNA #413 was cursing but had calmed down when he got to the door. CNA #413 stated Mother [expletive] stated he was going to hit me. LPN #386 revealed Resident #85 had never made false accusations about staff. Interview on 01/14/26 at 9:30 A.M. with LPN #392 who was working in the facility on 01/01/26. She stated she was in the conference room near the 400-hall eating lunch and heard a loud noise that sounded like chaos and voices. She stated CNA #413 was in the doorway handing out cigarettes to residents and using profanities at someone in the smoking area. She was unsure who CNA #413 was speaking too. LPN #392 verified there were no residents having behaviors or noted to be agitated. She was unsure what residents were in the smoking area but stated it was the usual smokers. LPN #392 revealed she wrote a handwritten statement and was told by management it had been misplaced so she was asked to email another statement on 01/02/26. LPN #392 did not remember seeing Resident #85 in the smoking area during the incident and verified that her typed statement was inaccurate. Review of the emailed witness statement dated 01/06/26 from LPN #392 to LPN #339 revealed on 01/01/26 LPN #392 was sitting in the conference room with several other staff having lunch when there was a loud commotion from the smoking area. LPN #392 followed the nursing supervisor to check on the situation. CNA #413 was standing in the doorway, passing out cigarettes, and screaming profanities. LPN #392 was unsure who CNA #413 was screaming the profanities too. LPN #392 did not hear any specific (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	threats toward any patients, only cursing. Review of the employee file for CNA #413 revealed she had a hire date of 12/09/24. CNA #413 had received her job description on hire which included for her to follow all resident rights and adhere to all facility policy and procedures. On 05/02/25 there was a disciplinary action form stating CNA #413 was arguing with the appearance of aggressive behavior or use of inappropriate, abusive or foul language towards or in the presence of a resident, employee or visitor. This was a final written warning. CNA #413 refused to sign the disciplinary action form. On 01/01/26 there was a disciplinary action form stating CNA #413 had been arguing with the appearance of aggressive behavior and use of foul language towards or in the presence of resident, employee or visitor. The CNA #413 was notified by phone of the termination by the Director of Nursing (DON) and HR Director #370. Review of the employee handbook, revised 06/15/23, revealed the facility has established certain rules, regulations and standards guiding employee behavior and conduct. Employees were expected to project a mature, professional and courteous attitude toward residents, visitors, and co-workers. The level of discipline given would be dependent upon the seriousness of the offense or performance concern. Class 2 work rule violations were considered serious. If they did not result in immediate termination, they would result in a final written warning for the first occurrence. Arguing, the appearance of aggressive behavior, or use of inappropriate abusive or foul language towards or in the presence of a resident, employee, or visitor is an example of class 2 work rule violations. This deficiency represents noncompliance investigated under Complaint Number 2645564.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observations, interviews, and facility policy reviews, the facility failed to ensure a thorough investigation was completed for verbal abuse during a self-reported incident (SRI) investigation. This affected one (Resident #85) out of eight residents reviewed for abuse. The facility census was 141.Findings Include:Review of the medical record for Resident #85 revealed an admission date on 08/25/22 with diagnoses including, but not limited to, unspecified dementia, alcohol dependence with alcohol-induced dementia, vascular dementia, anxiety, depression, insomnia, encephalopathy, and unspecified psychosis. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #85 had a Brief Interview Mental Status (BIMS) score of 09 indicating impaired cognition.Review of SRI #269286 from the facility on 01/01/26 revealed Certified Nursing Assistant (CNA) #413 made inappropriate comments to Resident #85. The staff member was suspended but had no previous disciplinary actions. A head-to-toe assessment, pain assessment, and skin assessment was completed on 01/01/26 with no negative findings. Resident #85 denied any physical contact with CNA #413. His guardian and doctor were notified of the incident. Interviews conducted with residents with BIMS of 09 or greater completed with no additional concerns identified. Assessments of residents with BIMS of less than 09 completed with no significant findings. Interviews with staff revealed no concerns. Social services followed up and Resident #85 was at baseline for mood and behaviors. The staff was re-educated on the abuse policy. CNA #413 had no previous disciplinary actions and a valid CNA license. The facility unsubstantiated the abuse allegation. The discovery date of the allegation was 01/01/26 and the SRI was completed on 01/04/26.Review of the witness statement from CNA #413 on 01/01/26 revealed Resident #85 was extremely agitated most of the day. CNA #413 denied making any other derogatory statements to Resident #85 or any other residents. This statement was taken by the Administrator and originally had CNA #413's last name incorrect.Review of the witness statement taken by the Administrator on 01/01/26 from Resident #01 (Resident #85's roommate) for SRI #269286 revealed that he had not heard any inappropriate statements and was only aware of the situation because Resident #85 had told him.Review of a hand-written witness statement by Licensed Practical Nurse (LPN) #392, dated 01/01/26, revealed she was sitting in the conference room having lunch and heard a loud commotion coming from the smoking area. LPN #392 went to investigate and saw CNA #413 standing in the doorway passing out cigarettes and screaming profanities. It was unclear who CNA #413 was yelling at. She stated the situation then settled down. LPN #392 did not hear her making specific threats toward any patients, only cursing.Review of a typed witness statement by LPN #392, dated 01/01/26, revealed she was sitting in the conference room with several staff having lunch when there was a commotion coming from the smoking area. Resident #85 was agitated yelling out. LPN #392 did not hear CNA #413 making any specific threats toward any residents.Review of a witness statement by LPN #386, dated 01/01/26, observed CNA #413 cursing and yelling near the common lounge area. CNA #413 was sent home by the supervisor for her behavior. Review of the emailed witness statement from 01/06/26 from LPN #392 to LPN #339 revealed on 01/01/26 she was sitting in the conference room with several other staff members having lunch. She stated there was a loud commotion coming from the smoking area. LPN #392 followed the nursing supervisor to check on the situation. CNA #413 was standing in the doorway, passing out cigarettes, and screaming profanities. LPN #392 was unsure who CNA #413 was yelling at and then the situation calmed down. LPN #392 did not hear specific threats toward any patients, only cursing.Interview on 01/08/26 at 9:28 A.M. with Resident #85 revealed CNA #413 was very inappropriate and always mean to people. He stated during the smoke break on 01/01/26, CNA #413 stated to him that he had a very small dick and her husband's was bigger. Resident (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#85 stated she was swearing at him. Resident #85 indicated his roommate (Resident #01) overheard the statements made because he was right next to him during the smoke break. He stated there were no other staff present.Interview on 01/08/26 at 9:30 AM with Resident #01 revealed CNA #413 made inappropriate comments to Resident #85 including the size of his penis and was using profanities at him. Resident #01 indicated the comments were made at smoking break and no other staff were present.Interview on 01/08/26 at 1:46 P.M. with the Human Resources (HR) Director #370 revealed CNA #413's last name on her employee file was correct and not the SRI.Interview on 01/08/26 at 2:26 P.M. with CNA #348 revealed on 01/01/26 there was a commotion at the smoking door. She stated she had observed CNA #413 and two residents arguing. CNA #348 was unsure why CNA #413 was not sent home immediately after, but she did not leave the facility until 3:00 P.M. CNA #348 indicated the facility was short-staffed that day. CNA #348 indicated CNA #413 had been observed treating residents without respect and dignity in the pastInterview on 01/12/26 at 10:54 A.M. with the Administrator revealed CNA #413's last name was not correct on the SRI. It was documented on the SRI that CNA #413 had no previous disciplinary actions however she had a previous disciplinary action in her employee file. The Administrator indicated the reason it was documented on the SRI that way was due to CNA #413 not having disciplinary actions toward residents or their care. CNA #413 was not added as the perpetrator to the SRI due to an oversight. The Administrator indicated being unaware of Resident #85's roommate being present during the incident. When the roommate was interviewed the verbiage used was what Resident #85 told him. The Administrator stated it was a he said, she said situation and the roommate was not asked if he was present during the incident. Resident #85's roommate was cognitively intact. The Administrator indicated not being aware of the allegation made until approximately 8:00 P.M. on 01/01/26.Interview on 01/14/26 at 9:30 A.M. with LPN #392 revealed she worked at the facility on 01/01/26. She stated she was in the conference room near the 400 hall eating lunch and heard a loud noise that sounded like chaos and voices. She stated CNA #413 was in the doorway handing out cigarettes to residents and using profanities at someone in the smoking area. She was unsure who CNA #413 was speaking too. LPN #392 verified there were no residents having behaviors or noted to be agitated. She was unsure what residents were in the smoking area but stated it was the usual smokers. LPN #392 revealed she wrote a handwritten statement and was told by management it had been misplaced so she was asked to email another statement on 01/02/26. LPN #392 did not remember seeing Resident #85 in the smoking area during the incident and verified that her typed statement was inaccurate.Review of the employee file for CNA #413 revealed she had a hire date of 12/09/24. CNA #413 had received her job description on hire which included for her to follow all resident rights and adhere to all facility policy and procedures. On 05/02/25 there was a disciplinary action form stating CNA #413 was arguing with the appearance of aggressive behavior or use of inappropriate, abusive or foul language towards or in the presence of a resident, employee or visitor. This was a final written warning. CNA #413 refused to sign the disciplinary action form. On 01/01/26 there was a disciplinary action form stating CNA #413 had been arguing with the appearance of aggressive behavior and use of foul language towards or in the presence of resident, employee or visitor. The CNA #413 was notified by phone of the termination by the Director of Nursing (DON) and HR Director #370.Review of the employee handbook, revised 06/15/23, revealed the facility has established certain rules, regulations and standards guiding employee behavior and conduct. Employees were expected to project a mature, professional and courteous attitude toward residents, visitors, and co-workers. The level of discipline given would be dependent upon the seriousness of the offense or performance concern. Class 2 work rule violations were considered serious. If they did not result in immediate termination, they would result in a final written (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	warning for the first occurrence. Arguing, the appearance of aggressive behavior, or use of inappropriate abusive or foul language towards or in the presence of a resident, employee, or visitor is an example of class 2 work rule violations. Review of the facility policy titled, Abuse, Neglect, Exploitation and Misappropriation of Resident Property, dated 11/21/16, revealed the facility was to have evidence that all alleged violations of abuse are thoroughly investigated and to report the results of all investigations to the State Survey Agency within five working days of the incident.This deficiency represents noncompliance investigated under Complaint Number 2615601.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure safe smoking interventions were in place for Resident #106 and failed to ensure fall interventions were implemented at all times for Resident #16 and Resident #25. This affected three residents (Resident #16, Resident #25, and Resident #106) out of eight residents reviewed for accidents. The facility census was 141.1.Review of the medical record for Resident #106 revealed an admission date of 05/17/17. Diagnoses included but not limited to chronic atrial fibrillation, chronic obstructive pulmonary disease and nicotine dependence. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #106 had intact cognition and required supervision for activities of daily living. Review of the physician's orders for January 2026 revealed that Resident #106 was ordered to wear a fire-retardant apron when smoking for safety. Review of the care plan dated 08/26/21 with a revision date of 9/21/22 for Resident #106 revealed that a smoking apron must be worn when smoking. Observation on 01/05/2026 at 1:37 P.M. revealed Resident #106 was observed smoking in designated area. Resident #106 had a cigarette burn hole on his left pant leg and was not wearing a smoking apron. This was verified by Certified Nursing Assistant (CNA) #502 at time of observation. Observation on 01/05/26 at 1:39 P.M. revealed Resident #106 was propelling himself to the door with the cigarette hanging from his mouth. CNA #502 approached resident politely and took the cigarette from his mouth. CNA #502 stated that she told a nurse a while back but couldn't remember which one that he needed a smoking apron. Interview on 01/08/26 at 8:03 A.M. with Director of Nursing (DON) verified that Resident #106's physician's order and care plan stated that Resident #106 should wear a smoking apron. Review of the facility policy dated 11/23/11 with a most recent revision date of 10/21/22 revealed that the facility provides a safe and healthy environment for residents including safety as related to smoking. 2. Review of the medical record for Resident #25 revealed they were admitted to the facility on [DATE] with diagnoses that included stroke, dementia, epilepsy, unsteadiness on feet, chronic kidney disease, and weakness. Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #25 used corrective lenses, was cognitively intact, required supervision or touching assistance for transfers, and had two or more falls since admission. Review of the physician orders revealed an order dated 09/10/25 for a pressure alarm to the wheelchair and for placement and function to be checked every shift. Review of the progress notes revealed on 09/08/25 Resident #25 had fallen when transferring from their wheelchair to the bedside commode and on 12/16/25 they had fallen out of their recliner while (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	trying to pick up an item up from the floor. Review of the care plan revealed Resident #25 was at risk for falls due to weakness, impaired balance, and impaired cognition and the goal was to minimize risk factors related to falls with interventions that included a chair alarm. An observation on 01/08/26 at 9:26 A.M. revealed Resident #25 was in their wheelchair self-propelling in the room, and then the resident was visualized self-transferring from their wheelchair to the bedside commode. On observation of the transfer an alarm pressure pad and alarm speaker were visualized on the wheelchair. When Resident #25 transferred out of the wheelchair to the bedside commode the alarm did not sound. An interview on 01/08/26 at 9:28 A.M. with Licensed Practical Nurse (LPN) #383 revealed the wheelchair alarm should have sounded when Resident #25 transferred out of the wheelchair. LPN #383 checked the function of the wheelchair alarm and verified it was not disconnected; it was not turned off; it did not function correctly and should have sounded when the resident transferred out of the wheelchair. When LPN #383 assisted Resident #25 from the bedside commode to the wheelchair it was noted the left wheel lock for the wheelchair was broken and did not lock the wheel. LPN #383 verified the wheel lock did not function correctly. Review of the facility policy titled Fall Management, dated 10/17/16 revealed the facility would reduce the risk of falls and reoccurrence of falls by care plan development, implementation of interventions, and ongoing monitoring. 3. Review of the medical record for Resident #16 revealed they were admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, Parkinson's, dementia, repeated falls, weakness, unsteadiness on feet, and history of falling. Review of the physician orders revealed an order dated 12/11/25 for a call don't fall sign in the room. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #16 was cognitively intact, required supervision or touching assistance for transferring and ambulating, and had a history of falls prior to admission. Review of the fall risk assessment dated [DATE] revealed Resident #16 was at risk for falls due to three or more falls in the last 90 days, displayed cognition behaviors, ambulated with problems, and was unsteady transferring. Review of the care plan dated 12/12/25 revealed Resident #16 was at risk for falls related to Alzheimer's disease, Parkinson's, generalized weakness, dementia, and history of falling the goal was to minimize fall risk factors; interventions included analyze previous falls to determine pattern or trends, call don't fall sign to room, and to ensure the call light is within reach. Review of the fall investigation dated 11/08/25 revealed Resident #16 fell in their room while independently ambulating. It was noted that the call light was not in reach and a new intervention of a call don't fall sign was implemented. An observation on 01/07/25 at 10:56 A.M. revealed Resident #16 was sitting in their recliner near (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on the left side of the room nearest to the hallway. On observation it was noted the call light was clipped to the room divider curtain outside of Resident #16's reach and the absence of a call don't fall sign in the room. An interview on 01/07/26 at 11:05 A.M. with LPN# 384 revealed interventions for a resident that is at risk for falls could include a call don't fall sign, assistive devices in reach, and a call light in reach. LPN# 384 verified the absence of a call don't fall sign and that the call light was out of reach for Resident #16. An interview on 01/07/26 at 12:00 P.M. with the Director of Nursing (DON) revealed the facility doesn't not have a call light policy. A review of the Treatment Administration Record (TAR) from 01/01/26 to 01/07/26 revealed documentation that a call don't fall sign was in Resident #16's room. Review of the facility policy titled Fall Management, dated 10/17/16 revealed the facility would reduce the risk of falls and reoccurrence of falls by care plan development, implementation of interventions, and ongoing monitoring. This deficiency represents noncompliance investigated under Complaint Numbers 2645564 and 2637112.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper diets were followed. This affected three residents (Residents #17, #71, and #106) out of five residents for nutrition. The facility census was 141.1. Review of the medical record for Resident #17 revealed an admission date of 12/19/25. Diagnoses included but not limited to fracture of the upper end of right tibia, muscle weakness, and osteoarthritis. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #17 had intact cognition and required supervision for eating and partial assistance for other activities of daily living. Review of the physician's orders for January 2026 revealed that Resident #17 was ordered a regular diet with regular texture and thin liquids diet with double entrees all meals, eggs grits and meat related to at risk for malnutrition. Review of the care plan dated 11/20/25 for Resident #17 revealed there was a potential for alteration in nutrition due to diagnoses. Interventions included but not limited to provide diet as ordered and honor preferences. Review of Resident 17's breakfast diet ticket revealed that he was on a regular diet with double meat/entree with sausage at breakfast. Interview on 01/05/26 at 2:17 P.M. with Resident #17 revealed that the portions sizes are not correct especially at breakfast. Observation on 01/06/26 at 8:06 A.M. of Resident #17's breakfast tray revealed that he did not receive double portions and no meat for breakfast. This was verified at time of observation with Certified Nursing Assistant (CNA) #350. Interview on 01/08/26 at 8:03 A.M. with Director of Nursing (DON) verified that Resident #17's physician orders for a regular diet with regular texture and thin liquids diet with double entrees all meals, eggs grits and meat related to at risk for malnutrition. 2. Review of the medical record for Resident #71 revealed an admission date of 03/30/16 and a readmission date of 09/23/16. Diagnoses included but not limited to anorexia, vascular dementia, and major depressive disorder. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #71 had severely impaired cognition and required supervision for eating and substantial assistance activities of daily living. Review of the physician's orders for January 2026 revealed that Resident #71 was ordered a regular diet with regular texture and thin liquids diet with fortified cereal and fortified eggs at breakfast. Review of the care plan dated 04/03/16 with the most recent revision date of 10/31/25 for Resident #71 revealed there was a potential for alteration in nutrition due to diagnoses. Interventions included but not limited to provide diet as ordered, honor preferences, and nutrient dense foods offered at meals. Review of Resident 71's breakfast diet ticket revealed that he was on a regular diet with fortified cereal and fortified eggs. Observation on 01/06/25 at 8:14 A.M. revealed that Resident #71 did not get his fortified cereal for breakfast. This was verified by CNA # 502 at time of observation. Interview on 01/08/26 at 8:03 A.M. with DON verified that Resident 71's physician orders for a regular diet with regular texture and thin liquids diet with fortified cereal and fortified eggs at breakfast. 3. Review of the medical record for Resident #106 revealed an admission date of 05/17/17. Diagnoses included but not limited to chronic atrial fibrillation, chronic obstructive pulmonary disease and nicotine dependence. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #106 had intact cognition and required supervision for activities of daily living. Review of the physician's orders for January 2026 revealed that Resident #106 was ordered to a no added salt, mechanical soft texture and thin liquids diet with fortified cereal and fortified eggs at breakfast. Review of the care plan dated 05/25/17 with the most recent revision date of 09/09/25 for Resident #106 revealed there was a potential for alteration in nutrition due to diagnoses. Interventions included but not limited to provide diet as ordered and honor preferences. Review of Resident 106's breakfast diet ticket (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed that he was on a no added salt mechanical soft diet with fortified cereal and fortified eggs. Observation on 01/06/26 at 8:28 A.M. revealed that Resident #106 did not receive his fortified cereal. This was verified by Corporate Dietary Manager #500 at time of observation. Interview on 01/06/25 at 9:03 A.M. with Dietary Manager (DM) #378 revealed that there were two new employees on the trayline being trained and must have missed the fortified cereals. Interview on 01/08/26 at 8:03 A.M. with Director of Nursing (DON) verified that the Resident #106's physician orders for a regular diet with regular texture and thin liquids diet with fortified cereal and fortified eggs at breakfast. Review of the facility policy dated 10/18 titled, Food First Program, revealed that when managing the nutritional status of the resident, it is vital to obtain their preferences. Honoring their food and beverage preferences and incorporating them into the resident's diet is an effective intervention. This deficiency represents non-compliance investigated under Complaint Number 2674639.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, medical record review, and facility policy review, the facility failed to ensure a resident who required dialysis received ongoing assessments of condition before and after dialysis treatments. This affected one Resident (#14) of one resident identified as receiving dialysis. The facility census was 141.Review of the medical record for Resident #14 revealed an admission date of 06/19/19 and diagnoses including end stage renal disease (ESRD), diabetes mellitus, dependence on renal dialysis, morbid obesity, chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF).Review of the plan of care dated 05/13/20 revealed Resident #14 received dialysis treatments three times per week for ESRD. It was noted Resident #14 frequently refused to go to dialysis treatments. Interventions included assist with transfer needs when going to dialysis, auscultate lung sounds as ordered, monitor for edema, check for new orders upon return from dialysis, send lunch with resident to dialysis, maintain communication with dialysis staff and physician, monitor labs, monitor shunt site for bleeding and signs/symptoms (s/s) of infection, monitor bruit and thrill, replace dressing as needed, and provide education regarding consequences of refusing dialysis.Review of physician's order dated 11/01/22 revealed order to check left arm arteriovenous (AV) fistula for bruit and thrill every shift.Review of physician's order dated 04/20/24 revealed Resident #14 had dialysis every Tuesday, Thursday, and Saturday at a location outside the facility. Resident #14's appointment time was 11:00 A.M.Review of Medicare Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #14 had a brief interview for mental status (BIMS) score of 15 indicating intact cognition. Resident #14 had no refusal behaviors noted on the assessment. Resident #14 received dialysis treatments.Further review of the medical record revealed no evidence of pre-treatment or post-treatment assessments related to dialysis treatments for Resident #14 were completed by the facility.Review of the dialysis center's communication forms from October 2025 to January 2026 revealed the center provided Resident #14's pre-treatment and post-treatment weights, blood pressure, temperature, and status/condition. The center also provided a list of medications administered while in center.Interview on 01/08/26 at 2:22 P.M. with Licensed Practical Nurse (LPN) #435 revealed she was Resident #14's regularly assigned nurse. LPN #435 stated Resident #14 had a binder he took with him to dialysis. LPN #435 stated she filled out a form with vitals and any s/s of pain or sickness. LPN #435 was unable to produce Resident #14's binder as he was at dialysis. LPN #435 was also unable to provide a sample of the form they filled out.Interview on 01/12/26 at 4:22 P.M. with Director of Nursing (DON) revealed she was unable to locate any assessments filled out by the facility pre and post treatment for Resident #14. DON confirmed the communication forms provided were completed by the dialysis center.Review of facility policy Dialysis Management dated 10/11/18 revealed the facility would assess monitor for complications, and provide adequate intervention in the management of those receiving dialysis based on physician orders and plan of care.This deficiency represents noncompliance investigated under Master Complaint Number 2712681.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and facility policy review, the facility failed to honor preferences. This affected six residents (#9, #17, #71, #105, #106, and #129) out of six residents for beverage preferences. This had the potential to affect 141 residents who received meals from the facility. No residents were identified as receiving nothing by mouth (NPO). The facility census was 141.Findings include: 1. Review of the medical record for Resident #17 revealed an admission date of 12/19/25. Diagnoses included fracture of the upper end of right tibia, muscle weakness, and osteoarthritis.Review of the care plan dated 11/20/25 for Resident #17 revealed there was a potential for alteration in nutrition due to diagnoses. Interventions included but not limited to providing diet as ordered and honoring preferences.Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #17 had intact cognition and required supervision for eating and partial assistance for other activities of daily living. Review of the physician's orders for January 2026 revealed that Resident #17 was ordered a regular diet with regular texture and thin liquids with double entrees all meals, eggs, grits, and meat related to at risk for malnutrition. Review of Resident 17's breakfast dietary ticket revealed that he was to receive eight ounces of orange juice.Interview on 01/05/26 at 2:17 P.M. with Resident #17 revealed that the portions sizes were not correct, especially at breakfastObservation on 01/06/26 at 8:06 A.M. of Resident #17's breakfast tray revealed that he did not receive orange juice for breakfast. This was verified at time of observation with Certified Nursing Assistant (CNA) #350.2. Review of the medical record for Resident #9 revealed an admission date of 08/26/20 with a readmit date of 02/01/24. Diagnoses included anxiety disorder, schizoaffective disorder, and osteoarthritis.Review of the care plan dated 09/01/20 with a most recent revision date of 11/11/25 for Resident #9 revealed there was a potential for alteration in nutrition due to diagnoses. Interventions included but not limited to providing diet as ordered and honoring preferences.Review of the most recent MDS 3.0 assessment dated [DATE] revealed Resident #9 had intact cognition and was dependent on staff for eating.Review of the physician's orders for January 2026 revealed Resident #9 was ordered a regular diet with pureed texture and thin liquids. Review of Resident 9's breakfast dietary ticket revealed that she was supposed to get orange juice and coffee.Observation on 01/06/26 at 8:13 A.M. of Resident #9's breakfast tray revealed that she did not receive orange juice or coffee. This was verified at time of observation with CNA #350.3. Review of the medical record for Resident #71 revealed an admission date of 03/30/16 and a readmission date of 09/23/16. Diagnoses included anorexia, vascular dementia, and major depressive disorder.Review of the care plan dated 04/03/16 with the most recent revision date of 10/31/25 for Resident #71 revealed there was a potential for alteration in nutrition due to diagnoses. Interventions included but not limited to providing diet as ordered, honoring preferences, and nutrient dense foods offered at meals.Review of the most recent MDS 3.0 assessment dated [DATE] revealed Resident #71 had severely impaired cognition and required supervision for eating and substantial assistance activities of daily living. Review of the physician's orders for January 2026 revealed that Resident #71 was ordered a regular diet with regular texture and thin liquids diet with fortified cereal and fortified eggs at breakfast.Review of Resident 71's breakfast dietary ticket revealed that he was supposed to get orange juice.Observation on 01/06/25 at 8:14 A.M. revealed that Resident #71 did not get orange juice for breakfast. This was verified by CNA # 502 at time of observation.4. Review of the medical record for Resident #129 revealed an admission date of 08/06/19. Diagnoses included multiple sclerosis, chronic obstructive pulmonary disease and schizophrenia disorder.Review of the (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care plan dated 08/08/19 with the most recent revision date of 11/15/25 for Resident #129 revealed there was a potential for alteration in nutrition due to diagnoses. Interventions included but not limited to providing diet as ordered and honoring preferences.Review of the most recent MDS 3.0 assessment dated [DATE] revealed Resident #129 had intact cognition and required supervision for eating and dependent on staff or other activities of daily living. Review of Resident #129's breakfast dietary ticket revealed that he was supposed to receive eight ounces of orange juice.Observation on 01/06/26 at 8:17 A.M. revealed that Resident #129 did not receive orange juice. This was verified by Licensed Social Worker (LSW) #372 at the time of the observation.5. Review of the medical record for Resident #105 revealed an admission date of 08/23/24. Diagnoses included metabolic encephalopathy, diabetes mellitus, and unspecified severe protein-calorie malnutrition. Review of the care plan dated 08/26/24 with the most recent revision date of 11/01/25 for Resident #105 revealed there was a potential for alteration in nutrition due to diagnoses. Interventions included but not limited to providing diet as ordered, honoring preferences, and nutrient dense foods offered at meals.Review of the most recent MDS 3.0 assessment dated [DATE] revealed Resident #105 had slightly impaired cognition and required supervision for eating and was dependent on staff for activities of daily living. Review of Resident 105's breakfast dietary ticket revealed that he was supposed to get four ounces of orange juice.Observation on 01/06/25 at 8:22A.M. revealed that Resident #105 did not get orange juice for breakfast. This was verified by LSW #372 at the time of the observation.6. Review of the medical record for Resident #106 revealed an admission date of 05/17/17. Diagnoses included chronic atrial fibrillation, chronic obstructive pulmonary disease and nicotine dependence.Review of the care plan dated 05/25/17 with the most recent revision date of 09/09/25 for Resident #106 revealed there was a potential for alteration in nutrition due to diagnoses. Interventions included but not limited to providing diet as ordered and honoring preferences.Review of the most recent MDS 3.0 assessment dated [DATE] revealed Resident #106 had intact cognition and required supervision for activities of daily living. Review of Resident 106's breakfast dietary ticket revealed that he was supposed to receive four ounces of orange juice.Observation on 01/06/26 at 8:28 A.M. revealed that Resident #106 did not receive orange juice. This was verified by Corporate Dietary Manager #500 at time of observation.Interview on 01/06/26 at 9:03 A.M. with Dietary Manager (DM) #378 revealed that there were two new employees on the tray line being trained and when they ran out of orange juice, they did not put another type of juice on the tray.Interview on 01/06/26 at 9:03 A.M. with Registered Diet Technician (DTR) #340 revealed that the average fluid amount per resident, who was not on a fluid restriction, was 1440 milliliters (ml) and the juice served at breakfast is equal to approximately 60 ml for four ounces.Review of the spreadsheet for breakfast on 01/06/26 revealed that residents were supposed to get four ounces of juice for breakfast. Review of the facility policy titled, Food First Program, dated 10/18, revealed that when managing the nutritional status of the resident, it is vital to obtain their preferences. Honoring their food and beverage preferences and incorporating them into the resident's diet is an effective intervention.This deficiency represents non-compliance investigated under Complaint Number 2628778.