STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365192	A. Building B. Wing	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenbrier Health Center	6455 Pearl Rd Parma Heights, OH 44130

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to revise a resident's care plan to reflect a residents current needs. This affected two of (Resident #69 and #117) of forty four sampled Residents. The facility census was 123.Findings include: 1. Resident #117 was admitted to the facility on [DATE] with diagnoses including Parkinsonism, Steele-[NAME]-[NAME] syndrome (an extremely rare brain disease that gradually impairs balance, eye movement, speech, and swallowing), and dementia. Review of Resident #117's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #117 was moderately cognitively impaired, utilized a walker for ambulation, and required setup assistance for completing activities of daily living. The assessment also documented that Resident #117 engaged in wandering behaviors every one to three days and identified his primary language as Russian. Review of Resident #117's care plan problem dated 07/19/25 revealed Resident #117 was considered an elopement risk related to dementia and Parkinsonism. Interventions included: administering medications as ordered; observing and documenting signs, symptoms, effectiveness, and side effects; educating the resident/resident representative about medication effectiveness and side effects; approaching and speaking in a calm manner; behavioral health consults as needed; communicating with the resident/resident representative regarding behaviors and treatment; encouraging the resident to express feelings and participate in activities of choice; encouraging the resident to maintain as much independence and decision-making as possible; intervening as necessary to protect the rights and safety of others; minimizing the potential for disruptive behaviors by offering tasks that divert attention; monitoring behavioral episodes and attempting to determine underlying causes; observing and anticipating the resident's needs such as thirst, food, body positioning, pain, and toileting needs; and praising any indication of behavioral progress. Review of a nursing progress note dated 07/27/25 at 6:59 P.M. revealed Resident #117 was in the smoking area when he kicked the gate open and eloped into the facility's parking lot. Emergency services were called by another resident in the parking lot, and emergency personnel assisted Resident #117 in returning to the facility. Resident #117 subsequently went directly to the nurses' station and began using the phone to make multiple calls and hang up. He then began pacing the halls carrying two bags. Resident #117 was approached and redirected by nursing staff, but he yelled, home, fly. The resident was then placed on one-on-one supervision due to exit-seeking statements and behaviors. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Nursing on 09/29/25 at 10:10 A.M. verified the events of the 07/27/25 elopement attempt and confirmed that the only direct intervention implemented afterward was one-on-one supervision. Review of a late-entry nursing progress note dated 09/15/25 at 8:00 A.M. revealed the facility was notified by the municipal police department at 12:50 A.M. on 09/15/25 that Resident #117 had been determined to be missing from the facility and was found approximately 1.7 miles away. The last known sighting of Resident #117 was at 10:30 P.M., when he was observed sitting in the television room on the second floor wearing blue jeans, a T-shirt, a blue jacket, and shoes. Review of a police report dated 09/15/25 revealed that at 12:08 A.M. Resident #117 was identified by a local resident at a home approximately 1.5 miles away from the facility. He was wearing a sweatshirt and plaid night pants. The local resident called emergency services after observing Resident #117 ring the doorbells of multiple homes in the area. Resident #117 was located in the street by police. When asked what he was looking for, Resident #117 stated he was searching for a local meat market. He further stated that his kidney hurt and was subsequently transported to a local hospital for evaluation. An interview with the Administrator on 09/24/25 at 10:10 A.M. confirmed that Resident #117's elopement/wandering care plan was not updated to include new interventions to address his multiple elopement attempts. 2. Record review for Resident #69 revealed an admission date of 07/21/23. Diagnosis included spondylosis, radiculopathy lumbar region, abnormal posture, and muscle weakness. Review of the Annual MDS dated [DATE] revealed Resident #69 was cognitively intact. Resident #69 had impairment on one side of the upper extremities and both sides of the lower. Resident #69 required assistants with activities of daily living (ADL's). Review of the medical record for Resident #69 from 09/01/24 through 09/22/25 revealed no documentation of any care plan meeting being completed. Interview on 09/25/2025 at 11:27 A.M. with Licensed Social Worker (LSW) #649 revealed she had Resident #69 down as having a care conference on 07/10/25 and 07/25/25. LSW #649 revealed there were no care conferences scheduled or completed prior to that stating, When I got here, they were a mess. LSW confirmed care plan meetings were to be held on admission, quarterly (every three months), and when there was a significant change in condition. LSW #649 revealed she will find and provide the documentation of the care plan meetings completed on 07/10/25 and 07/25/25. Interview on 09/30/25 at 2:00 P.M. with Administrator confirmed there was no documentation available to confirm any care plan meeting was completed for Resident #69 on 07/10/25 or 07/25/25.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents who were dependent on staff for activities of daily living (ADL) received showers as required. This finding affected 11 (Residents #8, #11, #27, #52, #58, #61, #69, #99, #110, #119, and #135) of 15 residents reviewed for showers. Facility census was 123. Findings include: 1. Review of Resident #8's medical record revealed the resident was admitted on [DATE] with diagnoses including dependence on renal dialysis, major depressive disorder and hyperlipidemia. Review of Resident #8's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition and required substantial/maximal assistance with shower/bathing. Review of Resident #8's Activities of Daily Living (ADL) Care Plan revealed an intervention dated 04/11/24 and revised 08/22/25 which stated the resident required substantial/maximal assistance for shower/bathing. Review of Resident #8's shower schedule revealed the resident was scheduled for showers on Wednesday and Sunday on nightshift. Review of Resident #8's shower documentation from 08/01/25 to 09/20/25 revealed the resident did not receive a shower on 08/03/25; was independent on 08/06/25; substantial assist on 08/10/25; moderate assist on 08/13/25; dependent on 08/17/25; substantial on 08/20/25; no shower on 08/24/25; no shower on 08/27/25; substantial on 09/03/25; independent on 09/07/25; independent on 09/10/25; assist on 09/14/25; and dependent on 09/17/25. A total of 13 bathing/shower entries with 10 showers/bathing completed and three showers/bathing not completed. Interview on 09/22/2025 at 4:44 P.M. with Resident #8 revealed he usually had to ask for showers. Interview on 09/23/25 at 2:48 P.M. with Licensed Practical Nurse (LPN) Unit Manager (UM) #629 confirmed Resident #8's showers were not completed as scheduled. 2. Review of Resident #27's medical record revealed the resident was admitted on [DATE] with diagnoses including encounter for orthopedic aftercare following surgical amputation, vascular dementia and peripheral vascular disease. Review of Resident #27's ADL Care Plan revealed an intervention dated 04/11/25 which stated the resident was dependent on tub/shower transfers with two or more staff assistance. Review of Resident #27's Quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment and the showers/bathing section was documented as not applicable. Review of Resident #27's shower schedules revealed the resident was scheduled for showers on Tuesday and Saturday on nightshift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #27's shower documentation from 08/01/25 to 09/20/25 revealed the resident did not have a shower on 08/02/25; refused on 08/05/25; no shower on 08/09/25; was dependent assist for a shower on 08/12/25; no shower on 08/16/25; no shower on 08/23/25; was dependent assist on 08/26/25; no shower on 08/30/25; no shower on 09/02/25; was dependent assist on 09/06/25; was dependent assist on 09/09/25; no shower on 09/13/25; was dependent on 09/16/25; and refused a shower on 09/20/25. A total of 14 entries with five showers/bathing completed, seven showers not completed, and two showers refused. Interview on 09/22/25 at 11:05 A.M. with Resident #27 revealed he has not had showers in approximately three weeks. Interview on 09/23/25 at 2:48 P.M. with LPN UM #629 confirmed Resident #27's showers were not completed as scheduled. Interview on 09/29/25 at 12:01 P.M. with MDS Coordinator #662 confirmed if a resident is indicated as not applicable for bathing, it is due to the resident was not bathing in the look back period. MDS Coordinator #662 confirmed Resident #27 was marked as not applicable on the most recent MDS assessment due to not having been bathed in the look back period. 3. Review of Resident #69's medical record revealed the resident was admitted on [DATE] with diagnoses including hyperlipidemia, primary osteoarthritis and age-related cognitive decline. Review of Resident #69's ADL Care plans revealed an intervention dated 07/29/24 and revised 05/02/25 which stated the resident was totally dependent on the assistance of one staff member for shower/bathing. Review of Resident #69's Annual MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition and the shower/bathing section stated not applicable. Review of Resident #69's shower schedule revealed the resident was scheduled for showers on Wednesday and Saturday on dayshift. Review of Resident #69's shower documentation from 08/01/25 to 09/25/25 revealed the resident was dependent assist for a shower on 08/02/25; refused on 08/06/25; no shower on 08/10/25, dependent assist on 08/13/25; no shower on 08/21/25; dependent assist on 08/23/25; substantial assist on 08/27/25; no shower on 08/30/25; dependent assist on 09/03/25; refused on 09/06/25; refused on 09/10/25; refused on 09/13/25; no shower on 09/17/25 and dependent on 09/20/25. A total of 14 entries with six showers, four refusals and four showers not completed. Interview on 09/22/25 at 10:28 A.M. with Resident #69 revealed the resident was not provided showers on a routine basis and has not had a shower for approximately two weeks. Interview on 09/25/25 at 12:29 P.M. with the Administrator confirmed the above findings. 4. Review of Resident #99's medical record revealed the resident was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia, contracture of the left shoulder and elbow and major depressive disorder. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #99's ADL Care Plan revealed an intervention dated 02/19/25 indicating the resident was totally dependent with two staff assistance for showers/bathing. Review of Resident #99's Quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment and the shower/bathing section was documented as not applicable. Review of Resident #99's shower schedule revealed the showers were scheduled on Thursday and Sunday on dayshift. Review of Resident #99's shower documentation from 08/01/25 to 09/22/25 revealed the resident did not receive a shower on 08/03/25; no shower on 08/10/25; received a bed bath on 08/14/25; no shower on 08/17/25; no shower on 08/21/25; no shower on 08/28/25; no shower on 08/31/25; no shower on 09/04/25; dependent assist on 09/07/25; refused on 09/11/25; dependent assist on 09/14/25; no shower on 09/18/25; and dependent on 09/21/25. A total of 13 entries with four showers/bathing completed, eight showers not completed, and one shower refused. Interview on 09/22/25 at 10:54 A.M. with Resident #99 revealed the resident was scheduled for showers on Tuesday and Thursday nights and was not provided with showers as scheduled. Interview on 09/23/25 at 2:48 P.M. with LPN UM #629 confirmed Resident #99's showers were not completed as scheduled. Interview on 09/29/25 at 12:01 P.M. with MDS Coordinator #662 confirmed if a resident is indicated as not applicable for bathing, it is due to the resident was not bathing in the look back period. MDS Coordinator #662 confirmed Resident #99 was marked as not applicable on the most recent MDS assessment due to not having been bathed in the look back period. 5. Review of Resident #110's medical record revealed the resident was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, muscle weakness and unspecified cirrhosis of the liver. Review of Resident #110's admission MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition and was documented as refused the bathing assessment. Review of Resident #110's ADL Care Plans revealed an intervention dated 08/18/25 which indicated the resident was totally dependent on one staff assistance for shower/bathing. Review of Resident #110's shower schedule revealed the resident was scheduled for showers on Monday and Thursday on nightshift. Review of Resident #110's shower documentation from 08/01/25 to 09/20/25 revealed the resident refused a shower on 08/07/25; refused on 08/11/25; was dependent assist on 08/14/25; was dependent assist on 08/18/25; no shower on 08/25/25; dependent assist on 08/28/25; dependent assist on 09/01/25; independent on 09/04/25; partial assist on 09/08/25; dependent assist on 09/11/25; refused on 09/15/25; no shower on 09/18/25; and no shower on 09/22/25. A total of 13 entries with seven showers completed, three showers not completed, and three showers refused. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 09/22/25 at 9:29 A.M. with Resident #110 revealed he did not receive showers as scheduled. Interview on 09/23/25 at 2:48 P.M. with LPN UM #629 confirmed Resident #110's showers were not completed as scheduled. 6. Review of Resident #119's medical record revealed the resident was admitted on [DATE] with diagnoses including hemiplegia and hemiparesis following a cerebral infarction affecting the right dominant side, chronic obstructive pulmonary disease, and diabetes. Review of Resident #119's ADL Care Plan revealed an intervention dated 12/05/24 which stated the resident was totally dependent with one person assist for shower/bathing. Review of Resident #119's Quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition and the bathing/shower assistance section was documented as not applicable. Review of Resident #119's shower schedule revealed the showers were scheduled on Monday and Friday on nightshift. Review of Resident #119's shower documentation from 08/01/25 to 09/20/25 revealed the resident refused a shower on 08/01/25; was dependent assist on 08/04/25; no shower on 08/08/25; no shower on 08/11/25; was dependent assist on 08/15/25; was dependent assist on 08/18/25; no shower on 08/22/25; was dependent assist on 08/25/25; was dependent assist on 08/29/25; was dependent assist on 09/01/25; was dependent assist on 09/08/25; was dependent assist on 09/15/25; no shower on 09/19/25; and no shower on 09/22/25. A total of 14 entries with eight showers completed, five showers not completed, and one shower refused. Interview on 09/22/25 at 9:21 A.M. with Resident #119 revealed she has not had a shower in approximately three weeks. Interview on 09/23/25 at 2:48 P.M. with LPN UM #629 confirmed Resident #119's showers were not completed as scheduled. 7. Review of Resident #135's closed medical record revealed the resident was initially admitted on [DATE], readmitted on [DATE] and discharged on 08/11/25 with diagnoses including hypothyroidism, muscle weakness and depression. Review of Resident #135's admission MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition and was documented as not applicable for showers/bathing. Review of Resident #135's closed medical record did not reveal evidence of the dates and shifts of the resident's showers, and the facility policy was at least two showers per week. Review of Resident #135's shower documentation from 08/01/25 to 09/10/25 revealed the resident was dependent assist for showers on 08/03/25 (bed bath); dependent assist on 08/07/25 (bed bath); no shower on 08/10/25; no shower on 08/13/25; was dependent assist on 08/17/25 (bed bath); no shower on 08/21/25; was dependent assist on 08/24/25; and no shower on 08/28/25. A total of eight entries with three bed baths completed, one shower completed, and four showers not completed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 09/23/25 at 2:48 P.M. with LPN UM #629 confirmed Resident #135's showers were not completed as scheduled. 8. Review of Resident #11's medical record revealed an admission date of 05/23/25 and diagnoses including adjustment disorder with anxiety, depression, unspecified psychosis, hypertension and dementia with psychotic disturbance. Review of an admission MDS 3.0 assessment dated [DATE] revealed Resident #11 had moderate cognitive impairment and was marked as not applicable for bathing. Review of Resident #11's plan of care for ADL self care performance revised 06/02/25 revealed Resident #11 required shower/bathing set-up and clean-up assistance. Review of Resident #11's nurses' notes did not document any recent refusals of showers. Review of Resident #11's point of care documentation for August and September 2025 revealed not applicable was documented on 08/01/25; there were blanks on 08/04/25 (Monday) and 08/08/25 (Friday); a bed-bath was documented on 08/11/25; a refusal was documented on 08/15/25; there were blanks on 08/18/25 (Monday) and 08/22/25 (Friday); showers were given on 08/25/25, 08/29/25 and 09/01/25; there was a blank on 09/05/25 (Monday); a shower was given 08/08/25; there were blanks on 09/12/25 (Friday), 09/15/25 (Monday) and 09/19/25 (Friday) and not applicable was documented on 09/22/25. Interview on 09/22/25 at 12:13 P.M. with Resident #11 revealed she'd not been bathed for two weeks. Interview on 09/25/25 at 2:09 P.M. with UM/LPN #629 verified Resident #11 only had five of her 16 scheduled showers in August and September 2025 and shared Resident #11 was not getting showers like she should on Mondays and Fridays. UM/LPN #639 stated she was not sure why not applicable was documented by staff as the correct options were shower given, bed bath given or refused. 9. Review of Resident #61's medical record revealed an admission date of 03/26/24 and diagnoses including hemiplegia and hemiparesis following cerebral infarction, chronic obstructive pulmonary disease (COPD), type two diabetes, epilepsy, generalized anxiety disorder and depression. Review of Resident #61's physician's orders revealed an order dated 04/13/24 for showers Wednesdays and Saturdays, document all refusals and timed for night shift on Wednesdays and Saturdays. Review of Resident #61's quarterly MDS 3.0 assessment revealed Resident #61 was cognitively intact and showering/bathing was marked as not applicable. Review of Resident #61's plan of care for ADL self care performance revised 07/01/25 revealed Resident #61 was totally dependent on one staff for showering/bathing. Review of Resident #61's nurses' notes did not document any recent refusals of showers. Review of Resident #61's point of care documentation and available paper shower sheets for August and September 2025 revealed on 08/03/25, no shower was attempted; a refusal on 08/07/25; a shower was provided on 08/11/25; showers were provided on 08/17/25, 08/21/25, 08/24/25, 08/28/25, 09/04/25, 09/07/25, 09/11/25, 09/14/25 and 09/18/25 with not applicable documented on 09/21/25. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 09/22/25 at 2:19 P.M. with Resident #61 revealed he did not receive showers like he was supposed to on Thursdays and Sundays. Interview on 09/24/25 at 4:36 P.M. with the Director of Nursing (DON) verified Resident #61 was provided 10 of 14 scheduled showers and confirmed the information provided was not evidence of routine resident bathing. 10. Review of the medical record for Resident #52's revealed an admission date of 10/03/24. Diagnoses included but were not limited to non-ST segment elevation myocardial infarction (NSTEMI) which is a heart attack with damage to the heart muscle, stage III chronic kidney disease, gastroesophageal reflux disease (GERD), and anxiety disorder. Review of the 07/15/25 quarterly Minimum Data Set (MDS) 3.0 for Resident #52 revealed intact cognition and noted Resident #52 required moderate assistance for bathing. Review of Resident #52's shower schedule revealed showers were to be given on night shift on Sundays and Thursdays. Review of Resident #52's shower documentation from 08/01/25 to 09/23/25 revealed Resident #52 did not receive a shower on 08/03/25; was independent on 08/07/25, required supervision on 08/10/25, was dependent on 08/14/25, required set up on 08/17/25, did not receive a shower on 08/21/25, resident was noted to refuse on 08/24/25, was dependent on 08/28/25, was dependent on 09/04/25, did not receive a shower on 09/07/25, was dependent on 09/11/25, required set up on 09/14/25, required maximum assist on 09/18/25, and required set up on 09/21/25. A total of 14 bathing/shower entries were recorded with 11 showers/bathing completed and three showers/bathing not completed by facility staff. Interview on 09/23/25 at 10:58 A.M. with Resident #52 revealed it had been since the previous Wednesday since she was showered. Interview on 09/25/25 with Unit Manager #629 revealed staff are supposed to document their shower and confirmed three showers were not completed as ordered in August and September of 2025 for Resident #52. Unit Manager #629 further stated staff should not have indicated showers not being applicable and should have documented a shower, bed bath or a refusal. 11. Review of the medical record for Resident #58 revealed an admission date of 09/16/22. Diagnoses included but were not limited to hemiplegia and hemiparesis, type I diabetes mellitus, paranoid schizophrenia, and post-traumatic stress disorder. Review of the 07/12/25 annual Minimum Data Set (MDS) 3.0 for Resident #58 revealed a brief interview of mental status (BIMS) score of 14 which indicated intact cognition. Under section GG0130 for functional abilities, shower/bathe self was indicated as not applicable. Review of Resident #58's care plan which was last reviewed on 08/06/25 revealed and activity of daily living (ADLs) self-care performance deficit related to cerebral infarct, muscle weakness and need for assistance with personal care. Resident #58 was noted to be totally dependent upon staff for bathing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #58's shower schedule revealed the resident was scheduled for showers on Monday and Thursday on nightshift. Review of Resident #58's shower documentation from 08/01/25 to 09/23/25 revealed resident was dependent on 08/04/25, did not receive a shower on 08/07/25 or 08/11/25, was dependent on 08/14/25, was dependent on 08/18/25, did not receive a shower on 08/21/25 or 08/25/25, was dependent on 08/28/25, was dependent on 09/01/25, 09/04/25, 09/08/25, 09/11/25, 09/15/25, required partial assistance on 09/18/25, and required substantial assistance on 09/22/25. A total of 15 bathing/showers were scheduled, and four of the fifteen showers/bathing were not completed by facility staff. Interview on 09/23/25 at 10:58 A.M. with Resident #58 revealed he gets showers once a week but not twice a week. Interview on 09/25/25 at 2:09 P.M. with Unit Manager #629 confirmed staff are supposed to document their showers in the medical record. Staff are not supposed to mark showers as not being applicable and should only mark if bathing was a shower, bed bath or refused. Unit Manager #629 confirmed Resident #58 was not given four of the fifteen showers between 08/01/25 to 09/23/25 as ordered. Interview on 09/29/25 at 12:01 P.M. with MDS Coordinator #662 confirmed if a resident is indicated as not applicable for bathing, it is due to the resident was not bathing in the look back period. MDS Coordinator #662 confirmed Resident #58 was marked as not applicable on the most recent MDS assessment due to not having been bathed in the look back period. Review of the undated facility policy called: Routine Resident Care revealed it is the policy of this facility to promote resident centered care by attending to the total medical, nursing, physical, emotional, mental, social and spiritual needs and honor resident lifestyle preferences while in the care of the facility. Unlicensed staff will provide routine daily care by a certified nursing assistant under the supervision of a licensed nurse such as bathing. 12.Record review for Resident #85 revealed an admission date of 12/10/10. Diagnosis included unspecified dementia, muscle weakness, and need for assistants with personal care. Review of Resident #85's Quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment and the shower/bathing section was documented as not applicable. Review of Resident #85's ADL Care Plan revealed an intervention dated 03/13/25 revealed the resident required substantial/maximal assistance with a tub/shower transfer. Observation on 09/22/2025 at 12:37 P.M. revealed Resident #85 was sitting up in bed. Resident #85's hair was oily, dischuffled, and her nails were embedded with dark substance. Resident #85 was difficult to understand. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the electronical tasks record for shower/bath for Resident #85 revealed Resident #85 was to receive a shower/bath every Monday and Friday. Record review revealed that of the eight showers/baths scheduled to be completed for July 2025, Resident #85 had no documentation of three of the eight being offered (07/04/25, 07/14/25, or 07/25/25). Record review revealed of the nine showers/baths scheduled to be completed for August 2025, Resident #85 had no documentation of three of the nine being offered (08/08/25, 08/18/25, or 08/29/25). Record review revealed of the six showers/baths scheduled to be completed for 09/01/25 through 09/21/25, Resident #85 had no documentation of three of the six being offered (09/05/25, 09/12/25, or 09/15/25). Interview and record review of the shower/bath record for Resident #85 on 09/29/2025 at 11:19 A.M. with DON confirmed Resident #85 had no documentation of the showers not completed being refused or offered. DON stated, If nothing was documented , the shower was not done. 13. Closed record review for Resident #123 revealed an admission date of 05/12/25 and a discharge date of 09/08/25. Diagnosis included cerebral palsy, morbid severe obesity, muscle weakness, and need for assistants with personal care. Review of Resident #123's Quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition and the shower/bathing section was documented as not applicable. Review of Resident #123's ADL Care Plan revealed an intervention dated 09/18/25 revealed the resident was totally dependent assistance of one staff member for personal hygiene. Record review of the electronical tasks record for shower/bath for Resident #123 revealed Resident #123 was to receive a shower/bath every Monday and Thursday. Record review revealed that of the eight showers/baths scheduled to be completed for August 2025, Resident #123 had no documentation of four of the eight being offered (08/07/25, 08/11/25, 08/14/25, or 08/21/25). Of the three shower/baths scheduled for September 2025, Resident #123 had no documentation of two of the three being completed (09/04/25 or 09/08/25). Interview and record review of the shower/bath record for Resident #123 on 09/29/2025 at 11:22 A.M. with DON confirmed Resident #123 had no documentation of the showers not completed being refused or offered. DON stated, If nothing was documented , the shower was not done. 14. Closed review of Resident #134's medical record revealed the resident was admitted on [DATE] and discharged on 05/31/25 with diagnoses including encounter for surgical aftercare, chronic obstructive pulmonary disease, muscle weakness, and need for assistants with personal care. Review of Resident #134's admission MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #134's ADL Care Plan revealed an intervention dated 05/29/25 for setup/cleanup assist for shower/bathing. Record review of the electronical tasks record for shower/bath for Resident #134 revealed Resident #134 was to receive a shower/bath every Wednesday and Saturday. Record review revealed that of the four showers/baths scheduled to be completed for May 2025, Resident #134 had no documentation of two of the four being offered (05/24/25 or 05/28/25). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and record review of the shower/bath record for Resident #134 on 09/29/2025 at 11:25 A.M. with DON confirmed Resident #134 had no documentation of the showers not completed being refused or offered. DON stated, If nothing was documented , the shower was not done. This deficiency represents noncompliance investigated under Complaint Numbers 1338811, 1338812, and 1338813.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure a comprehensive wound management system was in place to prevent and treat Resident #27 and #80's wounds and failed to ensure Resident #128's nephrostomy bandage was changed as ordered and Resident #136's intravenous (IV) dressings were completed as ordered. This finding affected four (Residents #27, #80, #128 and #136) of four residents reviewed for quality of wound care.Findings include:1. Review of Resident #27's medical record revealed the resident was admitted on [DATE] with diagnoses including encounter for orthopedic aftercare following a surgical amputation, vascular dementia and diabetes. Review of Resident #27's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment. Review of Resident #27's progress note dated 09/17/25 at 6:01 P.M. revealed the resident was observed by the nurse attempting to self-transfer from the bed to the wheelchair. The resident's wheelchair rolled backwards which caused the resident to slide to the floor. A skin tear was noted to the left lower leg (LLE) and left outer arm. Review of Resident #27's physician orders revealed an order dated 09/17/25 to cleanse the skin tear to the LLE with normal saline (NS), pat dry, apply triple antibiotic ointment (TAO) and cover with a foam dressing daily shift and as needed until healed. Review of Resident #27's medication administration records (MARS) and treatment administration records (TARS) revealed on 09/24/25, the wound care to the resident's left LLE was documented as completed by Licensed Practical Nurse (LPN) #608. Observation on 09/25/25 at 9:31 A.M. with Resident #27 revealed the resident was seated in his wheelchair in the doorway of his room. Observation of the LLE revealed the anterior shin area had a dressing which was dated 09/23/25. Observation and subsequent interview on 09/25/25 at 9:32 A.M. with Business Office Manager (BOM) #633 of Resident #27's LLE revealed the dressing was dated 09/23/25 and was not completed as ordered. 2. Review of Resident #136's medical record revealed the resident was admitted on [DATE] and discharged on 08/12/25 with diagnoses including altered mental status, local infection due to central venous catheter subsequent encounter and depression. Review of Resident #136's admission MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #136's hospital documentation dated 07/21/25 at 8:46 A.M. revealed the resident was sitting up in a chair and had a tunneled central line (CL) in the right chest. Review of Resident #136's progress note dated 07/26/25 at 12:55 P.M. authored by Nursing Student #694 revealed the resident arrived via a stretcher. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #136's physician orders revealed an order dated 07/28/25 (discontinued 08/12/25) to change the needleless connector every 24 hours with total parenteral nutrition (TPN); and an order dated 07/29/25 (discontinued 08/12/25) for TPN. Review of Resident #136's progress note dated 07/30/25 at 1:14 A.M. authored by Registered Nurse (RN) #714 revealed the resident accidentally disconnected the TPN line while attempting to go to the bathroom. The line site was intact with no visible signs of redness, swelling or drainage. The peripherally inserted central catheter (PICC) port was thoroughly cleaned with alcohol swabs using aseptic technique and the line was flushed properly with normal saline. A new administration set was connected without complications. Review of Resident #136's physician orders revealed an order dated 08/03/25 (discontinued 08/12/25) to change the CL dressing once weekly every night shift on Sunday. The MARS and TARS confirmed the CL dressing was changed on 08/03/25 and 08/10/25 by RN #714. Review of Resident #136's progress note dated 08/12/25 at 2:08 P.M. authored by RN #623 revealed the resident was discharged home and the discharge orders were provided. Review of Resident #136's home care Start of Care form dated 08/14/25 at 10:00 A.M. revealed the RN changed the central line dressing at the visit as the dressing was not intact and had not been changed since 07/24/25 which was reported to the home office. Review of Resident #136's undated photograph provided by Homecare Manager #735 revealed a photograph of a dressing which was partially coming off the resident's skin and the dressing was dated 07/24/25 at 12:30 P.M. Interview on 09/22/25 at 10:36 A.M. with Regional Director of Clinical Operations (RDOCO) #734 confirmed RN #714 had documented he had completed Resident #136's CL dressing on 08/03/25 and 08/10/25. Interview on 09/22/25 at 10:49 A.M. with RN #714 stated he did not remember if he actually changed Resident #136's dressing but he would not document that he completed the dressing if he did not actually do the dressing. He denied concerns with staffing but stated it was hard at times. A telephone call was placed on 09/22/25 at 10:58 A.M. with Home Care Manager #735 who revealed the resident's home care nurse let her know about the situation. She was familiar with the patient. When Resident #136 was discharged from the nursing home, the CL dressing was not changed, and the resident had been admitted to the nursing home for at least several weeks. 3. Review of the medical record for Resident #128 revealed an admission date of 07/12/25. Diagnoses included but were not limited to malignant neoplasm of bladder, malignant neoplasm of liver and intrahepatic bile duct, mild protein-calorie malnutrition, and anxiety disorder. Review of the 07/19/25 admission Minimum Data Set (MDS) 3.0 for Resident #128 revealed intact cognition. Review of the Activities of Daily Living (ADLs) for Resident #128 revealed set up was required for personal hygiene and was also noted to have a non-removable medical device. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician order dated 07/14/25 for Resident #128 revealed an order to cleanse the nephrostomy tube every three days on night shift with normal saline and cover with a Tegaderm (a transparent, waterproof, self-adhesive bandage used to protect wounds and secure medical devices) using sterile technique. Review of the physician order dated 07/15/25 for Resident #128 revealed an order to clean the nephrostomy tube with normal saline, pat dry, apply T-drain sponge, and secure with tape. Change or apply dressing every other day (QOD) and as needed (PRN) every day shift every other day for surgical care. Review of the September 2025 Treatment Administration Record (TAR) for Resident #128 revealed the 07/14/25 order to cleanse the nephrostomy tube every three days on night shift with normal saline and cover with a Tegaderm (a transparent, waterproof, self-adhesive bandage used to protect wounds and secure medical devices) using sterile technique was signed off as completed on 9/01/25, 09/03/25, 09/06/25, 09/09/25, 09/12/25, 09/15/25, 09/18/25, 09/21/25, 09/24/25, and 09/27/25. Review of the September 2025 TAR for Resident #128 revealed the 07/15/25 order to clean the nephrostomy tube with normal saline, pat dry, apply T-drain sponge, and secure with tape. Change or apply dressing every other day (QOD) and as needed (PRN) every day shift every other day for surgical care was signed off as completed on 09/01/25, 09/03/25, 09/05/25, 09/07/25, 09/09/25, 09/11/25, 09/13/25, 09/15/25, 09/17/25, 09/19/25, 09/21/25, 09/23/25, 09/25/25, and 09/27/25. Review of the care plan dated 07/14/25 for Resident #128 revealed a left nephrostomy tube related to diagnosis of Hydroureter (a condition where the ureter, the tube that carries urine from the kidney to the bladder becomes enlarged and filled with urine.) Interventions listed included changing the nephrostomy tube dressing per the practitioner's order. Interview on 09/22/25 at 11:09 A.M. with Resident #128 revealed he has a nephrostomy tube, and it had only been changed a couple of times since he was admitted on [DATE]. Interview on 09/23/25 at 1:04 P.M. with Resident #128 stated they had changed his bandage a couple of hours ago but was told it was supposed to have been completed on night shift. Interview on 09/23/25 at 2:21 P.M. with Registered Nurse (RN) #622 confirmed she had changed the dressing for Resident #128 a couple hours ago. RN #622 confirmed night shift was supposed to have changed it and was unsure why it was not completed. Interview on 09/29/25 at 11:31 A.M. with the Administrator confirmed the facility did not have a policy for care of a nephrostomy tube. Observation on 09/29/25 at 12:24 P.M. with the Director of Nursing (DON) revealed the bandage covering Resident #128's nephrostomy tube was dated 09/23/25. Interview with the DON following the observation confirmed Resident #128's dressing was dated 09/23/25 and should have been changed on 09/25/25, 09/27/25 and today. Interview on 09/29/25 at 12:27 P.M. with Resident #128 confirmed the nephrostomy tube dressing had not been changed since last week. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Phone interview on 09/29/25 at 3:22 P.M. with Licensed Practical Nurse (LPN) #656 revealed she worked on the day shift for 09/27/25 and 09/28/25 and thought the nephrostomy tube was flushed every couple of days on night shift. LPN #656 stated she worked the day shift, she did not change Resident #128's nephrostomy bandage on Saturday or Sunday and if it was signed off by her, it was accidental and not changed. Interview on 09/30/25 at 11:02 A.M. with the DON confirmed there were two orders for Resident #128's care of the nephrostomy tube care. The DON stated the order written to cleanse nephrostomy tube with normal saline and cover with a Tegaderm using sterile technique should not have been written due to the facility does not use Tegaderm bandages in the nursing facility. The DON confirmed staff should not have signed the order as completed and was inaccurate documentation. DON stated regarding the order to clean the nephrostomy tube with normal saline, pat dry and apply a T-drain sponge and secure with tape every other day and as needed should not have been signed off unless completed. DON also stated she had already spoken with both nurses who worked the day shift on 09/25/25 and 09/27/25 and both confirmed they signed off the order but had not completed the dressing change. Review of the undated Wound Care policy revealed residents/patients admitted with or develop skin integrity issues would receive treatment as indicated based on location, stage and drainage. 4. Record review for Resident #80 revealed an admission date of 07/10/17. Diagnosis included chronic obstructive pulmonary disease (COPD), need for assist with personal care, reduced mobility, and muscle weakness. Review of the care plan dated 11/26/24 revealed Resident #80 was incontinent of urine related to impaired cognition, impaired mobility and dementia. Interventions included to check Resident #80 for incontinence, change as needed. Review of the care plan dated 07/24/25 revealed Resident #80 had risk of skin breakdown related to arthritis, incontinence and limited mobility. Interventions included to administer treatments as ordered, encourage resident to turn and reposition, or assist as needed as resident allows and provide peri care as needed to avoid skin breakdown due to incontinence. Review of the most recent Wound Assessment for Resident #80 was dated 08/06/25 untimed, completed by Wound Care Certified Nurse Practitioner (CNP) #802, and revealed Resident #80 had sacrococcygeal candidiasis which involved 70% epithelial and 30% granulation tissue. The wound measured 10 centimeters (cm) by five cm with 0.2 cm depth. The treatment included cleanse with soap and water, pat dry, apply triad and A&D ointment four times a day and as needed. Record review revealed no further wound assessment with wound measurements or description. Review of the significant change MDS assessment dated [DATE] revealed Resident #80 was moderately cognitively impaired. Resident #80 had impairment on one side of the upper extremities. Resident #80 used a wheelchair for mobility, was always incontinent of bowel and bladder, and was dependent for toileting hygiene, personal hygiene, and bed mobility. Resident #80 did not have a pressure ulcer/injury or skin problems, was at risk for pressure ulcers/injuries. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan for Resident #80 dated 08/12/25 revealed Resident #80 had an activity of daily living (ADL) self care performance, required assistance with activities of daily living (ADL) related to weakness and limited mobility and had occasional urinary incontinence. Interventions included toileting hygiene and personal hygiene, helper does all effort, roll left and right, total dependence, resident required the use of mechanical lift with two-person support. Review of the September 2025 physician orders for Resident #80 revealed the resident to be up and fed in the dining room for all meals for supervision. An additional order dated 04/02/25 revealed apply triad paste to peri area every shift and as needed. An order dated 03/29/25 revealed barrier cream to buttocks and peri area every shift and as needed after incontinent episodes. An additional order dated 08/06/25 wound sacrococcygeal /groin cleanse with soap and water, pat dry, apply triad and A&D ointment to base of the wound Change QID (four times a day) and as needed. Interview on 09/22/2025 at 9:56 A.M. with Resident #80 revealed he had a wound on his buttocks from too much pressure. Observation on 09/23/2025 at 11:18 A.M. revealed Certified Nursing Assistant (CNA) #659 was assisting Resident #80 in his bed. CNA #659 revealed started her shift at 7:00 A.M. and revealed she just completed incontinence care for Resident #80 for the first time her shift. CNA #659 stated, I am behind, there's not enough aids. CNA #659 revealed Resident #80's buttocks was red. Observation revealed CNA #659 transferred Resident #80 to his wheelchair via mechanical lift with two assistants. CNA #659 revealed Resident #80 should be changed again at 1:00 P.M. Observation and interview on 09/23/25 at 1:00 P.M. revealed Resident #80 was in his wheelchair in his room in the same position as placed at 11:18 A.M.; Resident #80 revealed no one checked or changed him since he was assisted into the chair. Observation and interview on 09/23/2025 at 5:11 P.M. revealed Resident #80 was in his wheelchair in his room in the same position as placed at 11:18 A.M.; Resident #80 revealed no one still checked or changed him. Resident #80 stated, it's this way all the time. Interview on 09/23/2025 at 5:14 P.M. with Licensed Practical Nurse (LPN) #675 confirmed he was Resident #80's primary care nurse and confirmed he worked since A.M.; LPN #675 revealed Resident #80 had an order to be up in his chair for all meals but he should still be checked and changed every two hours. LPN #675 confirmed Resident #80 was not checked for incontinence or changed since he was assisted out of bed and confirmed CNA #659 ended her shift at 3:00 P.M.; LPN #675 stated, I don't know why he wasn't; we started with not enough staff. Observation on 09/23/2025 at 5:19 P.M. with CNA #606 and #618 transfer Resident #80 to bed from his chair and provide incontinence care revealed the chair cushion, the mechanical lift pad, Resident #80's pants and brief were all saturated with urine. Resident #80 had a foul odor of urine. Resident #80's buttocks and both thighs had several creases from the wrinkled pad. Resident #80's buttocks was red and there were three open areas in the sacral area. One of the three areas had yellow tissue in the bed of the wound. CNA #606 revealed he just started a few hours ago and did not get to Resident #80 yet to change him. Observation revealed CNA #606 then placed zinc cream, triad cream and peri shield cream in his hand and mixed the three together them applied a thick layer to Resident #80's buttocks and wounds. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 09/24/2025 at 11:06 A.M. with Wound Care CNP #802 confirmed her last visit with Resident #80 was on 08/06/25. Wound Care CNP #802 revealed when she last saw Resident #80, the wounds on his buttocks was caused by incontinence and revealed the pressure of him setting up all day could create pressure ulcers. Wound Care CNP #802 revealed the triad cream should be used as a light layer and it should not be mixed with other creams revealing it needs to be washed of with care and if a thick layer was applied it would be very difficult to wash off. Interview on 09/24/2025 at 12:31 P.M. with Unit Manager LPN #690 revealed she was also the facility Wound Care Nurse. Unit Manager LPN #690 revealed she had not been able to see Resident #80 since 08/06/25 with Wound Care CNP #802, Because he is always in his chair. Unit Manager LPN #690 revealed Resident #80 was supposed to get A&D ointment and triad cream to his buttocks and revealed everyone should be checked and changed every two hours. Unit Manager LPN #690 revealed Resident #80's wounds to his buttocks were caused from sitting up too long in his chair. This deficiency represents non-compliance investigated under Complaint Number 2596048, 2561886, and 1338808.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure Resident #38's pressure ulcer wound care dressings were completed as ordered. This finding affected one (Resident #38) of seven residents reviewed for pressure wounds. Findings include:Findings include:Review of Resident 38's medical record revealed the resident was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including quadriplegia, diabetes and schizophrenia.Review of Resident #38's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition.Review of Resident #38's physician orders revealed an order dated 09/17/25 to cleanse the mid-spine, right back, sacrum, right ischium, left buttock, right lateral leg and left lower extremity with wound cleanser, apply collagen sheet to the base of the wound and secure with a bordered foam dressing daily and as needed.Review of Resident #38's wound progress note dated 09/24/25 at 3:39 P.M. revealed the resident had a mid-spine pressure wound at a stage three which was improving and measured 2.1 centimeters (cm) length by 1 cm width by 0.3 cm depth; a right back stage 3 pressure wound which was improving and measured 3.3 cm length by 4 cm width by 0.3 cm depth; a sacrum stage three pressure wound which was improving and measured 4.6 cm length by 3 cm width by 0.2 cm depth; and a left buttocks stage three pressure wound which was improving and measured 7 cm length by 5.1 cm width by 0.2 cm depth. Interview on 09/24/25 at 12:16 P.M. with Licensed Practical Nurse (LPN) Wound Nurse #690 confirmed Resident #38's dressings to his mid spine, right back, sacrum, and the left buttocks dressings were signed off by LPN #707 on 09/23/25 as completed on the resident's medication administration records (MARS) and treatment administration records (TARS) but the dressings reflected a date of 09/22/25 which confirmed the dressings were not completed as ordered and the MARS and TARS were inaccurate. Review of the undated Wound Care policy revealed residents/patients admitted with or develop skin integrity issues would receive treatment as indicated based on location, stage and drainage. This deficiency represents non-compliance investigated under Complaint Numbers 2561886, 1338811 and 1338808.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, review of a police report, facility policy review, and interview, the facility failed to provide adequate supervision to prevent Resident #117, a cognitively impaired resident with a history of elopement from eloping. This resulted in Immediate Jeopardy and the potential for Actual Harm on 09/14/25 at approximately 10:30 P.M. when Resident #117 exited the facility without staff knowledge and was found by local police (on 09/15/25 at approximately 12:10 A.M.) in the middle of a residential street of a neighborhood approximately 1.7 miles from the facility. When found, Resident #117 was confused and speaking in his native language (Russian), asking to go to a local ethnic meat market. The resident was subsequently transported to the local hospital via emergency medical services (EMS) for evaluation.In addition, concerns that did not rise to Immediate Jeopardy occurred when the facility failed to maintain a safe environment related to smoking and failed to ensure resident smoking materials were kept in locked areas per the facility smoking policy to prevent an accident hazard. This affected one resident (#117) of three residents reviewed for elopement risk and wandering behaviors, three residents (#86, #103 and #113) and had the potential to affect 19 additional residents who reside in the facility and smoke including Resident #6, #27, #33, #46, #55, #58, #73, #79, #83, #87, #100, #104, #105, #106, #108, #110, #115, #119 and #127. The facility census was 123.On 09/23/25 at 4:42 P.M., the Administrator, Director of Nursing (DON), and Corporate Nurse Consultant (CNC) # 944, were notified Immediate Jeopardy began on 09/14/25 at 10:30 P. M. when Resident #117, who was at risk for elopement and exhibited a desire to leave the facility, was found out of the facility approximately 1.7 miles away by the local police department without staff knowledge. Resident #117 was subsequently found at approximately 12:10 A.M. by the police department in the middle of a residential street and was transferred to the local hospital via emergency medical services (EMS). The Immediate Jeopardy was removed on 09/17/25 when the facility implemented the following corrective actions: On 09/15/25 at 12:50 A.M. local police called facility and notified facility that Resident #117 was found outside and transported to the hospital. On 09/15/25 at 2:00 A.M., a headcount was completed by facility staff, to ensure each resident was accounted for.On 09/15/25 at 7:48 A.M., Resident #117 returned to the facility and was immediately assessed by the nurse.On 09/15/25, at 7:48 A.M., Resident #117 was placed on one on one (1:1) supervision with a plan for 1:1 supervision to remain in place until the resident was no longer identified as high risk for elopement which would be assessed quarterly using the wandering observation tool. On 09/15/25 10:00 A.M., Maintenance Director (MD) #712 completed an audit to validate all windows and doors were secure and functioning properly. On 09/15/25 at 10:00 A.M. the DON/designee reported to the facility Quality Assessment and Performance Improvement (QAPI) committee the concerns related to Resident #117's elopement. The QAPI committee met to complete a root cause analysis. The QAPI committee determined the facility failed to provide adequate supervision for the resident who was moderately cognitive impaired and at high risk for elopement. The facility determined the lack of adequate supervision was not related to staffing levels but rather to the specific needs of the resident with moderately impaired cognition who was at high risk for exit-seeking. At the time, this resident required more supervision than was being provided, resulting in placement on a 1:1 following the incident. The facility failed to recognize the heightened supervision needs that exceeded the usual requirementsOn 09/15/25 10:30 A.M. MD #712 changed all secure door codes.On 09/15/25 at 10:50 A.M. LPN #900 completed a wandering assessment, pain assessment and head to toe assessment on Resident #117.Between 09/15/25 at 1:51 P. M. and 09/17/25 the Administrator conducted staff education for all facility staff in person, via Onshift software (e-learning platform) and via phone calls related to Elopement prevention and management overview and Unit Supervision with emphasis on safety and supervision.On 09/16/25 at 9:51 A.M. Resident #117's physician and emergency contact was notified.On 09/16/25 at 4:00 P.M., the clinical interdisciplinary team which consists of the Director of Nursing (DON), assistant Director of Nursing and Unit Managers (UM's) #609 and #629 completed wandering/elopement assessments on all residents. On 09/16/25 at 6:00 P. M., elopement/wandering care plans were reviewed for all residents at risk by the DON/designee.On 09/16/25 at 6:40 P.M., the facility elopement binder was reviewed by the DON/designee.On 09/17/25 at 10:00 A.M. Resident #117's care plan was updated by Minimum Data Set Nurse (MDSN) #679 to include 1:1 supervision for an elopement intervention. On 09/17/25 at 10:10 A.M. two residents (Resident #37 and Resident #100) care plans were updated with elopement interventions by MDSN #679 Beginning 09/15/25

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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, record review and interview, the facility failed to provide Resident #119 with timely incontinence care. This finding affected one (Resident #119) of eleven residents reviewed for incontinence care. Findings include:Review of Resident #119's medical record revealed the resident was admitted on [DATE] with diagnoses including hemiplegia and hemiparesis following a cerebral infarction affecting the right dominant side, chronic obstructive pulmonary disease and diabetes.Review of Resident #119's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition, was frequently incontinent of bowel and bladder and required substantial/maximal assistance with toileting hygiene.Review of Resident #119's Activities of Daily Living (ADL) Self-Performance Care Plan revealed an intervention dated 05/09/25 which indicated the resident required substantial/maximal assistance with toileting hygiene.Observation on 09/22/25 at 9:45 A.M. of Certified Nursing Assistant (CNA) #687 of Resident #119's incontinence care revealed the resident's incontinence brief was saturated with urine and the resident's buttocks (right and left) appeared a deep red. The bedsheets beneath the resident had a large dried yellow stain underneath the resident.Interview on 09/22/25 at 9:52 a.m. with Resident #119 with CNA #687 in attendance revealed the resident was last changed on 09/21/25 around 8:00 P.M. and no one came in to check on her or change her incontinence brief. The resident stated she did not put the call light on because staff never came.Interview on 09/23/25 at 6:13 A.M. with Licensed Practical Nurse (LPN) #680 revealed Resident #119 was checked and provided incontinence care this morning around 5:30 A.M., which should be performed every two hours.Interview on 09/23/25 at 6:14 A.M. with CNA #602 revealed she worked from 7:00 P.M. to 7:00 A.M. on 09/21/25 into 09/22/25 and again on 09/22/25 into 09/23/25. CNA #602 revealed she checked and changed Resident #119 around 6:00 A.M. on 09/22/25 and did not notice a large yellow stain on the sheets which appeared dried.Review of the Perineal Care - Male and Female policy dated 2018 to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the residents' skin condition.This deficiency represents non-compliance investigated under Complaint Number 1338813, 1338811, 1338810 and 1338808.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of the facility assessment, the facility failed to ensure adequate staffing to meet resident needs. This affected 91 residents residing on the second floor (Residents #7, #8, #9, #11, #12, #13, #14, #15, #16, #17, #18, #19, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #34, #35, #36, #37, #39, #40, #41, #42, #43, #44, #45, #46, #48, #51, #52, #54, #55, #56, #58, #59, #60, #62, #64, #66, #68, #69, #70, #71, #74, #76, #77, #78, #79, #80, #82, #83, #85, #86, #87, #89, #90, #92, #95, #96, #97, #100, #101, #102, #104, #105, #106, #107, #110, #111, #112, #113, #114, #115, #116, #117, #118, #119, #121, #124, #125, #127 and #138). Facility census was 123.Findings include:Review of the facility assessment, updated 07/10/25, revealed for an average census of 122 residents, based on the facility's resident population and their needs for care and support, our approach to staffing is to ensure each of our facility residents has the minimum care staff to meet the needs of the residents at any given time. Each resident receives individualized care. The care each resident receives is subject to continuous review and improvement. Services and care we offer based on our residents' needs included activities of daily living (bathing/showers, oral/denture care, dressing, eating, support with needs related to hearing/vision/sensory impairment and supporting resident independence in doing as much of these activities by himself/herself.) A table listed for day shift revealed for nurse aides on Unit 4-2AB, Unit 4-2C and Unit 4-2D, there were to be 3-4 CNAs on each unit, reaching a minimum of nine CNAs on the second floor. Review of staffing schedules for September 2025 for day shift (12-hour shift) on the second floor revealed the following:- On 09/01/25, seven CNAs plus nine hour split shift,- On 09/02/25, six CNAs plus four hour split shift,- On 09/03/25, five CNAs plus 23.75 hours split shift,- On 09/04/25, six CNAs plus 18. 25 hours split shift,- On 09/05/25, four CNAs plus 30 hours split shift,- On 09/06/25, eight CNAs,- On 09/07/25, seven CNAs,- On 09/08/25, six CNAs plus 8.5 hours split shift,- On 09/09/25, four CNAs plus 21. 25 hours split shift,- On 09/10/25, six CNAs plus 22 hours split shift,- On 09/11/25, seven CNAs,- On 09/12/25, five CNAs,- On 09/13/25, six CNAs plus 21.75 hours split shift,- On 09/14/25, seven CNAs,- On 09/15/25, six CNAs plus nine hours split shift,- On 09/16/25, five CNAs plus 19.25 hours split shift,- On 09/17/25, four CNAs plus 12 hours split shift,- On 09/18/25, five CNAs plus 11 hours split shift,- On 09/19/25, seven CNAs,- On 09/20/25, six CNAs plus 3.5 hours split shift,- On 09/21/25, six CNAs,- On 09/22/25, six CNAs plus 4 hours split shift,- On 09/23/25, four CNAs plus 6.5 hours split shift,- On 09/24/25, six CNAs,- On 09/25/25, five CNAs plus 10 hours split shift.Interview on 09/23/25 at 2:16 P.M. with Human Resource Manager (HRM) #671 revealed the facility outsourced their scheduling to a company in Dubai. HRM #671 reported the facility had not used agency staff to meet facility staffing needs in the two years she had been employed by the facility and reported the facility worked off of a 3.1 per-patient-day (PPD) ratio.Interview on 09/29/25 at 8:32 A.M. with the Administrator during review of the facility assessment revealed on the second floor's unit D, they staffed with two to three CNAs which she acknowledged could have been clearer within the facility assessment. The Administrator stated due to this, there should be a minimum of eight CNAs on day-shift on the second floor. The Administrator was made aware during the interview that all 25/25 days reviewed for staffing during September 2025 did not meet the minimum amount of CNA coverage for the second floor per the provided facility assessment and that staff and resident interviews along with care observations showed inadequate staffing levels pertaining to the second floor to which the Administrator did not disagree.The following concerns were identified related to insufficient staffing in the facility:a. Interview on 09/22/25 at 9:21 A.M. with Resident #119 revealed she had not had a shower in three weeks and did not bother putting her call light anymore as staff did not address her needs timely. b. Interview on 09/22/25 at 9:29 A.M. with Resident #110 reported waiting up to 1.5 hours for assistance and shared concerns with showers as a result of short-staffing. c. Observation and interview on 09/22/25 at 9:52 A.M. of Resident #119's incontinence care with Certified Nursing Assistant (CNA) #687 revealed Resident #119's bilateral buttocks were reddened, her adult brief was soaked and the bed had a large yellow stain on it. Resident #119 stated she was last changed around 8:00 A.M. and no one had come in to change her.Interview on 09/22/25 at 9:53 A.M. with CNA #687 stated staff were to ask Resident #119 if she wanted to be changed.d. Interview on 09/22/25 at 10:17 A.M. with Resident #69 revealed she requested no male aides so when a male aide was scheduled on the floor, they don't come in to her room but then no one else is assigned to come into her room. Resident #69 stated there's not enough staff so she would not be changed timely and

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation of medication administration, interview, record review, and review of the instructions for insulin pen-injections, the facility failed to ensure medications were administered as ordered resulting in a medication errors rate of 6.7 percent (%). This affected two residents (Resident #87 and #138) out of five residents observed for medication administration. The facility census was 123.Findings include:1. Record review for Resident #138 revealed an admission date of 05/20/25. Diagnosis included diabetes mellitus with diabetic chronic kidney disease.Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #138 was cognitively intact. Resident #138 received insulin injections daily. Review of the Care Plan dated 06/02/25 revealed Resident #138 had diabetes with diabetic neurological complications. Interventions included to administer insulin injections per medical providers orders.Review of the physician orders for Resident #138 dated 08/28/25 revealed orders for Insulin Lispro subcutaneous (sq) solution pen-injector 100 units per ml, inject four units sq with meals for blood sugar. Observation on 09/23/2025 at 11:38 A.M. of medication administration with Licensed Practical Nurse (LPN) #721 prepare and administer insulin to Resident #138 revealed LPN #721 removed the Lispro insulin pen from the medication cart. LPN #721 placed the needle on the pen and dialed in four units. Observation revealed LPN #721 did not prime the pen. LPN #721 then administered the insulin to Resident #138.Interview on 09/23/2025 at11:42 A.M. with LPN #721 confirmed she did not prime the insulin pen prior to administration to Resident #138 and revealed she didn't need to prime the insulin pen. LPN #721 revealed she worked all areas of the facility.2. Record review for Resident #87 revealed an admission date 07/22/25. Diagnosis included type two diabetes mellitus with hyperglycemia.Review of the admission MDS dated [DATE] revealed Resident #87 was cognitively intact. Resident #87 received insulin injections daily.Review of the Care Plan dated 08/01/25 revealed Resident #87 had diabetes. Interventions included to administer insulin injections as ordered.Review of the physician orders for Resident #87 revealed an order dated 07/26/25 for insulin Glargine Solostar sq solution pen-injector 100 units per ml inject 34 unit sq in the morning for diabetes. Observation on 09/24/25 at 8:35 A. M. of medication administration for Resident #87 revealed LPN #800 removed the Glargine Solostar pen-injector from the medication carts. LPN #800 primed the pen injector then placed the needle on the pen injector. LPN #800 then dialed in 34 unit on the pen injector and administered the insulin to Resident #87. LPN #800 confirmed she primed the insulin pen injector prior to putting the needle on and confirmed she did not prime the injector after putting the needle on. LPN #800 revealed she had worked all areas of the facility. Review of the Instructions for Use insulin kwik-pen revised 07/2023 revealed the priming process should be performed before every injection to ensure the correct dose is delivered. Without priming, you may inject air instead of insulin leading to an underdose. To prime, attach a needle, dial two units, tap to remove air, press the dose knob, you should see a drop or stream of insulin appear at the needle tip. If no insulin appears, repeat. Once a drop of insulin appears , your pen is primed and ready. You can now dial the correct dose for your injection.

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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** Based on interview, record review, and review of the facility policy, the facility failed to ensure Resident #133 and Resident #136 was free from significant medications error. This affected two residents (Resident #133 and #136) of three residents reviewed for medication errors. The facility census was 123.Findings include: 1.Record review for Resident #133 revealed an admission date of 01/14/25 and a discharge date of 03/26/25. Diagnosis included Crohn's disease, muscle weakness, abdominal pain, and other chronic pain. Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #133 was moderately cognitively impaired. Resident #133 received scheduled and as needed pain medications. Pain frequency was almost constantly and frequently had an effect on sleep. Review of the care plan dated 02/02/25 revealed Resident #133 has complaints of acute/chronic pain or at risk for pain related to Crohn's disease, intervertebral disc degeneration, lumbosacral region, abdominal pain, vitreous degeneration, other chronic pain. Interventions included to provide medications per order and observe for pain every shift. Review of the physician orders dated 01/15/25 revealed an order for Gattex (used for short bowel syndrome to enhance gastrointestinal absorption) subcutaneous (sq) kit five milligrams (mg) (teduglutide (rdna) inject 0. 15 milliliters (ml) sq at bedtime for irritable bowel syndrome (IBS). Review of the Medication Administration Record (MAR) for Resident #133 for administration of Gattex kit five mg for 01/15/25 through 01/27/25 revealed a nine (9) was documented for each day with the exception of 01/21/25 which a check mark indicated the medication was given. A number six was documented from 01/28/25 through 01/31/25. Review of the chart code indicated a number nine indicated other/see nurses note. A number six indicated hospitalized . Resident #133's pain ranged from zero to 10. Review of the MAR for February 2025 revealed Resident #133 received the Gattex kit five mg five of the 28 days. A two (indicating the drug was refused) was documented two of the 28 days and a nine (indicating see nurses notes) was documented 21 of the days. Resident #133's pain ranged from zero to nine. Review of the MAR for March 2025 revealed Resident #133 received the Gattex kit five mg 11 of the 18 days residing at the facility. Resident #133's pain ranged from zero to nine. Review of the progress notes for January, February and March 2025 on the dates a nine was placed on the MAR for Resident #133 revealed documentations the medication Gattex was either on order or unavailable. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/29/2025 at 10:12 A.M. with Certified Nurse Practitioner (CNP) #744 revealed she was Resident #133's CNP when she resided at the facility. CNP #744 revealed Resident #133 had chronic pain for years, she received Gattex for Crohn's/short bowel syndrome therapy. The medication, Gattex, was ordered by the gastrointestinal specialist at the hospital. CNP #744 revealed missed doses of Gattex could affect/increase Resident #133's pain. CNP #744 revealed while at the facility, she shared a locked office with the unit managers and physicians. CNP #744 revealed she saw (Resident #133's) Gattex several times in the locked office stating, the medication was in the facility but not available for nurses to give, as it was locked in the physician provider office. Nurse management knew the medication was in the office, but not the floor nurses, so there was a miscommunication of location of the medication. CNP #722 revealed she poke to (LPN #690) who was the unit manager at that time, and it was also discussed in the Interdisciplinary Team meetings (IDT) meetings. CNP #722 told them it should be given as ordered, but they still didn't give it. CNP #744 didn't know if it was they wanted nurse managers to give it to prevent errors, but she talked to them several times, and it was part of the resident's regimen for short bowl syndrome. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #136's medical record revealed the resident was admitted on [DATE] and discharged on 08/12/25 with diagnoses including altered mental status, local infection due to central venous catheter subsequent encounter and depression.Review of Resident #136's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition.Review of Resident #136's progress note dated 07/26/25 at 12:55 P.M. authored by Nursing Student #694 revealed the resident arrived via a stretcher.Review of Resident #136's physician orders revealed an order dated 07/26/25 (discontinued 07/28/25) for amoxicillin-potassium clavulanate tablet 875-125 milligrams (mg) give one tablet by mouth every twelve hours for a bacterial infection for six days (12 doses); and an order dated 07/28/25 for amoxicillin-potassium clavulanate tablet 875-125 mg give one tablet by mouth every 12 hours for an infection of the venous catheter positive for Enterobacter cloacae bacteria for six days (12 doses).Review of Resident #136's progress note dated 07/27/25 at 8:41 P.M. authored by Registered Nurse (RN) #683 revealed the resident was ordered amoxicillin-potassium clavulanate tablet 875-125 mg give one tablet by mouth every 12 hours for a bacterial infection for 6 days (12 doses).Review of Resident #136's progress note dated 07/28/25 at 9:40 P.M. authored by Licensed Practical Nurse (LPN) #721 revealed the resident received amoxicillin-potassium clavulanate tablet 875-125 mg give one tablet by mouth every 12 hours for infection of the venous catheter which was positive for Enterobacter cloacae for 6 days for a total of 12 doses.Review of Resident #136's progress note dated 08/12/25 at 2:08 P.M. authored by RN #623 revealed the resident was discharged home and the discharge orders were provided.Review of Resident #136's medication administration records (MARS) and treatment administration records (TARS) from 07/26/25 to 08/12/25 revealed the resident did not receive the amoxicillin-potassium clavulanate antibiotic tablet due at 9:00 A.M. and 9:00 P.M. on 07/26/25 at 9:00 P.M. (waiting for pharmacy to deliver), 07/27/25 at 9:00 P.M. (waiting for pharmacy to deliver), 07/28/25 at 9:00 P.M., 07/31/25 at 9:00 A.M., and 08/01/25 at 9:00 P.M. (waiting for pharmacy to deliver). The MARS and TARS revealed the resident received 11 doses of the antibiotic. Interview on 09/22/25 at 10:36 A.M. with Regional Director of Clinical Operations (RDOCO) #734 confirmed the resident missed two doses of the antibiotic per the medical record.A telephone interview was conducted on 09/23/25 at 7:22 A.M. with Pharmacist #736 who revealed the pharmacy received two orders for the antibiotic with the first one on 07/26/25 and the second one on 07/28/25. Pharmacist #736 revealed staff removed the antibiotics for Resident #136 from the facility medication dispensary.A telephone interview was conducted on 09/23/25 at 9:02 A.M. with Pharmacist #737 who revealed Resident #136's antibiotics were pulled individually from the medication dispensary machine with one antibiotic tablet removed on 07/27/25, one antibiotic tablet removed on 07/28/25, two antibiotic tablets removed on 07/29/25, two antibiotic tablets removed on 07/30/25, one antibiotic tablet removed on 07/31/25, one antibiotic tablet removed on 08/01/25 and one antibiotic tablet removed on 08/02/25 (total of 9 tablets pulled from the medication dispensary machine). Pharmacist #737 confirmed only nine antibiotics were removed from the medication dispensary machine and not the twelve as ordered.Review of an email provided by Pharmacist #737 dated 09/23/25 at 9:44 A.M. of the dispensary record of the amoxicillin-potassium clavulanate tablet 875-125 mg from the facility medication dispensary revealed one antibiotic was removed on 07/27/25, one tablet on 07/28/25, two tablets on 07/29/25, two tablets on 07/30/25, one tablet on 07/31/25, one tablet on 08/01/25 and one tablet on 08/02/25.Review of the Medication Administration Policy dated 09/2025 revealed the purpose of the policy was to provide guidance for general medication administration to be provided by personnel recognized as legally able to administer. Medications would be charted when given and administered within the time frame of one hour before up to one hour after the time ordered.This deficiency represents non-compliance investigated under Complaint Numbers 2596048, 1338812 and 1338809.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365192	A. Building B. Wing	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenbrier Health Center	6455 Pearl Rd Parma Heights, OH 44130

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of the facility policy revealed the facility failed to ensure stored medications for residents use were not expired and were kept at an appropriate temperature for use and failed to ensure Resident #61 medications were not left at bedside unsecured without confirmation of administration. This affected one resident (Resident #61) and had the potential to affect all residents residing at the facility. The facility census was 123. Findings include:1. Observation and interview on 09/23/25 at 12:05 P.M. of the medication storage room with Unit Manager (UM) #629 revealed expired stock medications located in the storage room. UM #629 revealed the stocked medications were for the use of all residents residing at the facility who may have or may acquire an order for the medications. UM #629 confirmed the following medications were expired:-One bottle of Tylenol 650 milligrams (mg) 200 tabs with an expiration date of 07/2025.-Four bottles enteric coated Aspirin 325 mg 1000 tabs with an expiration date of 06/2024 and two additional bottles with an expiration date of 04/2024.-One bottle of Geri Max 12 fluid ounces antacid and anti gas with an expiration date of 03/20/25 and two additional bottles with an expiration date of 11/2024. -Nine bottles of Docusate Sodium 16 ounces 50 mg /five milliliters (ml) with an expiration date of 06/2024. Interview on 09/23/25 at 12:25 P.M. with Supply Coordinator #604 revealed she was supposed to be going through the medication supplies more often and disposing of the expired medications. Supply Coordinator #604 and UM #629 confirmed the expired medications.2. Observation on 09/23/25 at 2:38 P.M. with Director of Nursing (DON) of the medication storage refrigerator revealed the temperature in the refrigerator was 50 degrees Fahrenheit (F). DON confirmed the temperature of the inside of the refrigerator. Observation revealed inside the refrigerator was dripping water. The bottom of the refrigerator had a puddle of water. Inside was three vials of stock Lispro insulin unopened, three Lantus pens unused, six vials of Infuvite injections, two Trulicity pens and a Micafungin injection 50 mg/100mg. DON confirmed the refrigerator was above the recommended temperature for storing medications.Review of the information regarding storage revealed Micafungin injection 50 mg/100mg was to be stored in the refrigerator at 36 F - 46 F. Insulin was recommended to be stored in a refrigerator at approximately 36 -46 F. Review of the facility policy titled, Storage of Medication effective September 2025 revealed medications and biologicals are stored safely, securely, and properly, following manufacturers recommendations or those of the supplier. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal.3. Record review for Resident #61 revealed an admission date of 03/26/24. Diagnosis included hemiplagia and hemiparesis following cerebral infarction, epilepsy, high-density lipoprotein (HDL), insomnia, glaucoma, anxiety, nerve pain, and diabetes mellitus. Review of Resident #61's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition and required assistants with activities of daily living.Review of the Care Plan for Resident #61 dated 04/06/24 included Resident #61 was at risk for a mood problem related to depression, insomnia, generalized anxiety disorder, disease process and pain. Resident #61 also had a neurological disorder related to epilepsy, cerebral infarction, cognitive communication deficit, and lack of coordination. Interventions included to administer medications per the physician orders.Review of the physician orders for medications to be administered in the evening/bedtime for Resident #61 for July 2025 included: Atorvastatin calcium 80 milligrams (mg) give one by mouth at bedtime for HDL, Melatonin oral cap five mg, give two caps by mouth at bedtime for insomnia, Buspirone hcl oral tablet 10 mg, give one tablet by mouth two times a day for anxiety, and Levetiracetam oral tablet 750 mg, give two tablets every morning and at bedtime for epilepsy. Interview on 09/24/25 at 3:58 P.M. with Resident #61 revealed a nurse had left medications in his room for him to take later and revealed one nurse had a habit of doing it, LPN #692.Interview on 09/24/2025 at 4:02 P.M. with Director of Nursing (DON) revealed there was a concern with LPN #692 but was unable to recall the date. DON revealed the morning the complaint was made, (Resident #61) said meds were left at the bedside. DON confirmed LPN #692 worked the night shift 12 hours 7:00 P.M. to 7:00 A.M.; DON revealed on that day, she called LPN #692 on the phone because she had already left for the day. LPN #692 revealed she did set them down for him to take them and went into the hall. He did not take them according to the nurse.Interview and record review of Resident #61's medical record on 09/25/2025 at 9:26 A.M. with DON confirmed there was no documentation in the medical record of the medications left at the bedside. DON confirmed the medications were

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	365192	A. Building B. Wing	10/08/2025

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and staff interviews, the facility failed to ensure the facility was maintained a clean and sanitary environment. This had the potential to affect all 123 residents residing in the facility.Findings include:An environmental tour was conducted on 09/29/25 between 8:00 A.M. and 8:45 A.M. The following concerns were observed and verified by Housekeeping Director #999 at the time of discovery:The handrails in the hallways throughout the facility were noticeably chipped, scuffed, and rough to the touch.The light fixtures in the hallways throughout the facility contained noticeable areas of dust, dirt, and dead insects inside the fixtures.Resident #52's light fixture above the bed was missing a light bulb.The rooms of Residents #27, #32, #52, #84, and #139 had multiple water-stained ceiling tiles.The privacy curtains in the rooms of Residents #76, #85, and #104 were noticeably stained.The walls in the rooms of Residents #12, #14, #82, and #107 were severely scuffed.The wall-unit air conditioners in the rooms of Residents #114 and #127 displayed a clean filter indicator light, and the filters were coated with dust.The bathroom doors in the rooms of Residents #14, #74, #82, and #107 were severely damaged and scraped.The protective cover to the heat pipe in the rooms of Residents #45 and #64 was completely detached.The protective wood wall covering in the rooms of Residents #59 and #125 had a noticeable hole/gouge.The wheelchairs utilized by Residents #28 and #62 were extremely dirty, with significant accumulations of food, dirt, and other debris.Resident #123's room had a visible crack in the wall.The cover to the wall telephone line outside Resident #27's room was missing, exposing the live telephone wire.This deficiency represents non-compliance investigated under Complaint Number 2603578.