STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365289	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Lane Nursing and Rehabilitation	5425 High Mill Avenue NW Massillon, OH 44646

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and policy review, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner. This had the potential to affect 160 residents who ate meals prepared by the facility's kitchen, as two residents (Resident #3 and #23) were ordered nothing by mouth and did not receive meals from the kitchen. The facility census was 162. Findings include:Observation of the kitchen on 01/28/26 from 2:18 P.M. to 3:16 P.M. revealed the following: at 2:32 P.M. the sanitizing level of a bucket of quaternary cleaner (QUAT) (a disinfectant that uses ammonium compounds) on the three compartment sink was checked with QUAT paper (testing papers made of litmus paper used to measure the concentration level) and was below the required 150-200 parts per million (ppm), at 2:33 P.M. the bucket of QUAT located near the dishwashing station was below the required 150-200ppm, at 2:34 P.M. the bucked of QUAT located in the main food preparation area was below the required 150-200ppm, a layer of dust and grime on the top and side of the juice dispenser, a bulk storage tub of sugar in the main food preparation area was unlabeled, a layer of dust and grime on top of the standing oven and steamer, a layer of grime on the wall near the fryer, a layer of grime on the wall where the hood fire suppression system was mounted, and a box of frozen hash browns was open with the interior bag unsealed.An interview on 01/29/26 at 3:06 P.M. with the Dietary Manager revealed QUAT buckets should be changed every two to three hours, there is a cleaning schedule for the kitchen, and they verified the above findings.Review of the undated facility policy titled Sanitation and Food Handling revealed sanitary conditions will be maintained and cloths when not in use would soak in appropriate sanitizing solution.Review of the facility policy titled Purchasing, Receiving, and Storage Policy, dated 01/2021 revealed all supplies would be clearly labeled.

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review, interview, and observation, the facility failed to provide a dignified dining experience on the Memory Care Unit (MCU), and failed to ensure Resident #9 was provided dignity and respect at all times This affected ten residents (#10, #18, #32, #49, #69, #83, #105, #125, #139 and #142) out of 22 residents observed in the dining room, and one (Resident #9) of one resident reviewed for abuse.Findings include:1.Observation on 01/28/26 at 12:04 P.M. of the MCU dining room revealed 22 residents sitting at seven different tables. Two certified nursing assistants (CNAs), CNA #912 and CNA #937, were passing the trays from the cart in the nearby hallway. Also assisting in the dining room were Activity Director (AD) #817 and Human Resources (HR) #819. Observations on 01/28/26 at 12:05 P.M. of table one revealed Resident #18, Resident #69 and Resident #138 were all seated. Resident #138's family had walked in and took him to another dining area. Resident #69 was eating his meal while Resident #18 was looking around or watching Resident #69. At 12:15 P.M. Resident #18 stood up and walked out of the dining room without eating. Resident #69 returned to the dining room at 12:20 P.M. as Resident #18 was done with his meal and he got up and left. A CNA sat down and assisted Resident #69 with his meal. Observation on 01/28/26 at 12:06 P.M. of table two revealed Resident #32, Resident #83, Resident #125 and Resident #142 were seated. AD #817 was standing over and feeding Resident #83 for about five minutes before sitting down and assisting her once a chair was available. The other three residents did not have their meals yet. At 12:10 P.M. AD #817 and HR #819 were speaking across the table to each other while Resident #32's meal was placed in front of him. HR #819 stated she thought that he would eat it if staff handed him the food or utensil. AD #817 responded I don't think so stating he would eat it if placed in front of him. HR #819 did hand him a sandwich and he started eating it. HR #819 left the dining room. AD #817 continued to help Resident #83. At 12:15 P.M. Resident #125 had his meal in front of him. At 12:18 P.M. Resident #142 received his meal. Observation on 01/28/26 at 12:07 P.M. of table two revealed Resident #10, Resident #49, Resident #105, and Resident #129 were seated. Residents #10, #105 and #129 received their meals at 12:07 P.M. Resident #49 received his meal at 12:17 P.M. Interview on 01/28/26 at 12:50 P.M. with CNA #912 revealed there was no seating chart for the dining room. She stated the trays come on the cart in room order and they grab them off the cart in that order. They do not pass out per table. Interview on 01/28/26 at 12:56 P.M. with Unit Manager (UM) #822 revealed there was not necessarily a seating plan but they tried to be consistent on where residents sat. They passed the trays out as they pulled them off the cart. She verified the meals were not passed out at each table at the same time. Interview on 01/28/26 at 6:00 P.M. with Administrator revealed she was made aware of the concern in MCU dining room. She verified there was no specific facility policy for serving meals in the dining room. 2. Review of the Physical Abuse Self-Reported Incident (SRI) #268796 investigation revealed on 12/18/25 at 3:30 P.M., Resident #9 reported to Licensed Social Worker (LSW) #805 that he was upset (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with Certified Nursing Assistant (CNA) #903 who provided a shower. Resident #9 felt the CNA should had been more attentive and could have done a better job covering the resident while traveling in the hallway. An abuse and neglect in-service was started. Residents on the 100 and 200 halls were asked if they felt safe with no negative findings. Skin checks were started on residents on the 100 and 200 halls with no negative findings. The physician and family were notified. Review of Resident #9's medical record revealed the resident was admitted on [DATE] with diagnoses including type two diabetes, anxiety disorder and other chronic pain. Resident #9 resides on the 200 hall. Review of a text message from Resident #9's daughter to the Director of Nursing (DON) dated 11/05/25 at 4:50 P.M. revealed CNA #903 walked past the daughter three times and ignored the family member who needed ice. CNA #903 was going up the other hallway and talked with another CNA and stared at the family member. It upset the daughter. Review of Resident #9's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition and was dependent for showering and bathing. Review of the undated facility witness statement identified as a verbal conversation with CNA #903 revealed on 12/17/25, the aide showered Resident #9 in the shower room on the 400 hall. The resident was transported using a Hoyer mechanical lift into a wheelchair and wrapped in a bath blanket. The resident was then transported using a Hoyer mechanical lift to a shower chair. CNA #803 provided privacy while the resident showered and stood behind the wall. When the resident was finished, the resident was dried and then had another CNA on the 400 hall help Hoyer the resident back into the wheelchair. The resident was wrapped in a blanket and pushed back to the room. CNA #903 then went to the nursing station to ask for help getting the resident back to bed. The resident's feet/back were not washed as the aide thought the resident had done them himself. Review of the undated facility witness statement authored by Resident #9 revealed on 12/17/25, CNA #903 took the resident to a shower room. The resident was completely undressed but wrapped in a blanket. The shower was completed on another hallway due to the size of the shower room. During the shower, CNA #903 stood behind the wall while the resident washed the arms, torso and genital area. Once finished, CNA dried off the resident and transported the resident using a Hoyer mechanical lift back into the wheelchair and then pushed the resident back to the room. Once in the room, CNA #903 left the resident wrapped in a blanket sitting in the doorway in the wheelchair. The aide was gone for approximately 25 minutes. Review of a text message from Resident #9's daughter to the DON dated 12/18/25 at 11:16 A.M. revealed the daughter had received a call from the resident about a CNA the family had problems with before that was not supposed to be dealing with the resident. The CNA gave the resident a shower on 12/17/25 and did stuff to the resident in the morning on 12/18/25. The family did not understand why this happened. Review of a text message from the DON to Resident #9's daughter dated 12/18/25 at 1:49 P.M. revealed the facility talked to the resident and owned up to yesterday's issue with CNA #903 providing care on the 200 hall. The DON did not realize CNA #903 was assigned to the hall so that was the fault of the facility and the staff member was only over there until two and then another staff member took over. The DON also told Resident #9 that she would obtain a statement from the aide and the other residents that were having concerns so that it can be placed in the employee's file. The (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DON was getting statements, and the concerns would be placed in the file so disciplinary actions of these things would be addressed. Interview on 01/28/26 at 3:15 P.M. with the DON confirmed Resident #9's family member had texted her about CNA #903 on 11/05/25 and she had called the family member back to identify the concern. The DON revealed the resident's daughter had reported on 11/05/25 that they did not want CNA #903 to provide care for the resident. When questioned, the DON stated the facility did not report this to CNA #903 on 11/05/25 because the resident did not report the concern, who was alert and oriented, and the daughter had reported the concern. Interview on 01/29/26 at 6:22 A.M. with CNA #903 confirmed the incident with the shower occurred on 12/17/25 and the aide had told Resident #9 to let him know if he needed help during the shower. CNA #903 felt the resident deserved privacy and was waiting on the other side of the wall to help dry the resident off. CNA #903 confirmed both he and another staff member used a Hoyer mechanical lift and lifted the resident from the shower chair back into the wheelchair following the shower and drying the resident off. The resident was wrapped a bath blanket to roll the resident from the 400 hall shower room to the resident's room on the 200 hall because he forget to bring the resident's clothing to the shower room. CNA #903 indicated when he reached the 200 hall, he placed the resident, who was still wrapped in a bath blanket, in the resident's doorway while he went to get another staff member to assist with the Hoyer mechanical lift. CNA #903 stated the resident was in the doorway approximately 10 minutes while the other staff member finished her work in order to help him. CNA #903 denied intentional abuse or neglect. CNA #903 also confirmed Resident #9 was not provided dignity and respect at all times due to being in visual view of other residents on the 200 hall and sitting in a bath blanket in a wheelchair with no other clothing on. CNA #903 was not aware that he should not have been providing care to Resident #9 per the family's request. Review of CNA #903's schedules from 11/05/25 to 12/18/25 revealed the aide was scheduled the 100 hall on 11/20/25, 11/27/25, 12/18/25 and 200 hall on 12/17/25 (the 100 hall and 200 halls were attached to each other). Review of the Activities of Daily Living (ADLs) policy revised 04/2023 revealed staff to provide assistance to the residents for care that they were no longer able to perform on their own. The facility would encourage as much self-care as the resident was able to perform and assist with the completion of tasks unable to complete. All residents would be provided assistance, as needed, and as indicated on the care plan for bathing, toileting or incontinence care, dressing, eating, grooming, general hygiene, oral care, transfers and ambulation. The level of assistance and self-care would be resident specific.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews with families and staff and observations on the Memory Care Unit (MCU) the facility failed to provide meaningful activities to Resident #18. This affected Resident #18 and had the potential to affect all 27 residents on the MCU. Findings include:Review of the medical record for Resident #18 revealed an admission date of 03/22/18. Diagnoses included intracranial injury with loss of consciousness of unspecified duration, dementia, dysphagia, aphasia and major depressive disorder. Review of the annual Minimum Data Set (MDS) 3.0 dated 01/13/26 revealed Resident #18 had cognitive impairment. He was independent with walking. Review of preferences for routine revealed snacks were very important, reading and animals were not important and music was somewhat important. Review of the Activity assessment dated [DATE] completed by Resident #18's wife revealed his participation in activities was none. Resident #18 enjoyed motorcycle riding. He watched TV. He would be interested in pet visits. He would respond with prompts and cues. Review of care plan for Resident #18 revealed a goal of engaging in activities (actively or passively) such as 1:1 visits, independent leisure and group activities with assist/set-up as needed. It was initiated 03/29/18 with revision on 02/27/25. Resident #18 also had a goal of interacting with family/significant others and staff initiated on 11/25/2019 and revised on 02/27/25. Interventions included offer conversation and make eye contact, 1:1 visits and encourage participation in activities. Review of his activity participation for the past 30 days revealed the following were checked off: coffee cart (11 times), juice cart (30 times), radio (27 times), T.V. (28), beach ball (1 time), daily chronicle (30), provide new monthly activity calendar (1 time) and nails (3 times). Review of the MCU activity calendar for November 2025, December 2025 and January 2026 revealed activities such as bean bag toss, balloon toss, warm cookies and cocoa, painting, handwashing, movies, music and activities off the unit such as bingo, craft, trivia, Jeopardy and church service on Sundays. No animal visits noted. Interviews on 01/27/26 at 9:46 A.M. and 01/28/26 at 9:04 A.M. revealed Resident #18's family was concerned he was not provided enough activities to keep him busy. She realized he may not participate in an activity the whole time but wanted to see a variety of opportunities. Tour on 01/27/26 at 10:33 A.M. of the MCU revealed a long hallway after you enter the unit. The enclosed dining room was on the right which had seven tables with chairs around them. There was no one in the dining room. Going down the long hallway there were about 5 rooms on either side with some doors utilized by staff only. At the intersection was a small, nursing station on the right. The hallway intersected with another hallway (longer), making a T-shape for the unit. There was a TV lounge with couches and chairs where the hallways met and across from the nursing station. There were seven residents sitting with the TV on. Some residents had their eyes closed. One resident had an overbed table in front of her with some items to fidget with however her eyes were closed and she was not interacting with items. There were several residents wandering around and past the TV lounge including Resident #18. Observation of two activity staff pushing a cart with papers on the unit. They were engaged with each other as one was training the other. They left the unit within 20 minutes. When turning right at the nursing station there was another common room about halfway down called the parlor with a TV, some tables and chairs and some other furniture. Looked out at enclosed courtyard. There were five residents in the parlor with the TV on and the nurse with her medication cart. Several residents were roaming the hallways. The unit had minimal decorations including some framed paintings on walls. The unit had no evidence of seasonal decorations or a posted activity calendar in common area. There was no evidence of music playing in resident rooms including Resident #18's. Interview and observation on 01/27/26 at 10:43 A.M. of Certified Nursing Assistant (CNA) #912 revealed her redirecting wandering residents, including Resident #18, by nursing station. Staff did not offer any activity or task to engage resident. Interview on 01/27/26 at 11:03 with Unit Manager (UM) #822 revealed activities were usually held two to three times on MCU. She stated when (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	there was an entertainer for the whole facility residents from MCU may be taken off the unit. She stated they get a ball out or do exercise by nursing staff. UM #822 stated activities does nails and snacks. Observation on 01/27/26 at 11:11 A.M. revealed two activity staff entered the unit with hydration cart. They left the unit at 11:24 A.M. Observation on 01/28/26 from 9:58 A.M. through 1:00 P.M. revealed no music playing including in Resident #18's room. Observation on 1/28/26 from 10:11 A.M. to 10:23 A.M. of two activity staff passing milkshakes. They were on the unit for less than 15 minutes. Review of the activity calendar revealed arts and crafts were scheduled at 10:00 A.M. There was no observation of this activity. Observation on 01/28/26 of dining room from 12:04pm.-12:57 P.M. revealed Resident #18 sitting at table while table mate ate lunch as he did not have his meal yet. Resident #18 got up after about 15 minutes. He came back at 12:20 P.M. when staff assisted him with his meal that just arrived. Interview on 01/28/26 at 5:42 P.M. with DON revealed she had been at facility for about six months. She stated she sent a letter to families in November to announce a dementia support group. DON stated she had a hydration project she started on MCU. She was researching dementia care and making plans to enhance MCU including using red plates for meals, using shadow boxes for each resident and training staff using well-known dementia expert's education/videos. DON stated she was starting to create a sensory room but it was locked and not available for residents at this time. The program would be used company wide. The program was not in place at this time. Observations and interviews on 01/29/26 from 9:05 A.M.-9:11 A.M. on MCU revealed no one was in the dining room, Interview at 9:10 A.M. with CNA #961 revealed he thought it was nail day and confirmed no activity was happening at the time. Observation of five residents in the TV lounge and no one in the parlor thought the TV was on. Interview on 01/29/26 at 9:11 A.M. with Activity Aide (AA) #829 revealed she was just passing through through the unit. She was not working on the MCU however she said she has in the past. She stated they will be getting nails done at 10:30 A.M. Review of the calendar revealed at 9:00 A.M. was supposed to be baking cookies and cocoa in the parlor and at 10:00 A.M. they were having ice cream in the parlor and 11:30 A.M. was handwashing. Nails were not mentioned for this date. AA #829 stated Resident #18 did not always participate though he may go to a sing-along or a Veteran's program. Interview and observation with AD #817 on 1/29/26 at 9:20am revealed she came to tell surveyor the Activity Aide was on her way over for the 9:00 A.M. activity but she had to complete an assessment that was due first. The AA was also training someone. At 9:22 A.M. AA #826 entered the unit with the hydration cart and snacks. AD #817 continued to say the majority of the morning should be on the unit. She stated in the afternoons they may take from one to six residents off the unit to a larger activity. There were 27 residents on MCU. AD #817 verified the calendar said Baking Cookies and Cocoa at 9:00 A.M., Ice Cream at 10:00 A.M. and Handwashing at 11:30 A.M. She stated she put handwashing on the calendar to help remind team but stated it should be a part of resident care and not considered the activity. Subsequent interview on 01/29/26 at 9:41 P.M. with Activity Director (AD) #817 revealed one of her staff was still in training but that person would be on MCU. Her staff will rotate. She stated activity staff spend the morning on the unit (9 A.M. to 12:00 P.M) as residents were more likely to participate then. She stated it was their goal to keep an activity staff on the unit. AD #817 said they were slowly introducing sensory things saying it's a project. She said there was a locked room on MCU designated for sensory however it was not available yet to residents. AD #817 described her role more as documentation and paperwork though she sometimes did activities especially parties. She stated there were two activity aides plus her Monday through Friday. On the weekends they had one activity aide. Weekend activities included bingo, current events, media room in town square and church. Nursing staff would help bring residents. She stated they did low key stuff on weekends but believed they had enough staff. She stated there were magazines and games throughout the facility. Interview and observations on 01/29/26 at 10:22 A.M. with Registered Nurse #950 revealed activities were getting better but she had previous experience with dementia units that had more gadgets and items to occupy residents. She stated there was a secured room with some sensory items but the facility was still working (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	toward that. Observation of multiple residents coming up to the nursing station, including Resident #18, were redirected after a brief interaction with staff. No opportunities of engagement were offered. There was no observation of music playing on unit or in Resident #18's room. Interview on 01/29/26 at 3:08 P.M. revealed Resident #18's 1:1 included walking with him which lasted about three minutes. She had told the staff not to document those since it was so short. She stated they had not been marking residents as refusals. She said they were starting now. Review of letter sent to family members, dated 11/07/25, and authored by DON revealed they were announcing a dementia support group for families on MCU. It included a bibliography page for families to complete about their loved one. Review of the facility policy titled Activity Programs, last revised 08/2021, revealed Activity Directors shall plan and organize a program of activities for Residents on a group level and for individuals, to meet the objective of the department. The facility shall ensure the following protocol was followed: #2 Residents who were unable or not willing to participate in group programs shall receive 1:1 programming based on their interests, abilities and likes. Residents shall be encouraged but not forced to participate. #3 Resident refusals to participate in activities shall be recorded in the resident record.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on interviews, observation and resident handbook the facility failed ensure a clean homelike environment. This affected three residents (Resident #51, #172, and #178) out of five residents reviewed for physical environment. The facility census was 162. Findings Include:1. On 01/27/26 at 10:44 AM Resident #178 room revealed the bedside commode (BSC) had a small amount of urine and bowel movement (BM) in it dried and when the bathroom door was opened there was BM all around the toilet riser, toilet base and on the floor by the toilet. Resident #178 was not in the room at that time. At 10:53A.M. Resident #178 came back from getting her hair done At10:55 A.M. with Register Nurse #821unit manager and Licensed Practical Nurse (LPN) #902 stated Resident #178 takes herself to bathroom. Resident #178 stated yes, she does take herself to the bathroom and it has been a few days ago that she used her BSC. At 10:59 A.M. RN #821 cleaned up the bathroom. Observation at 1:50 P.M. of the BSC in Resident #178's room revealed it still had not been cleaned. No housekeeping has been seen on the hall.Interview on 1/28/26 at 7:53 A.M. with Housekeeper (HK) #860 revealed she worked over the weekend but did not work yesterday. HK #860 revealed on Saturday they worked the 700 and 800 hall and Sunday 200 hall. Resident rooms get cleaned everyday if there is a housekeeper on the hall and usually they have a housekeeper on each hall but on the weekends there may not be. On 01/28/26 at 11:29 A.M. RN #821 verified the BSC in Resident #178 had dried urine and BM in the bottom of the tub. RN #821 stated it should have been cleaned during housekeeping or by the Certified Nurses Assistant (CNA) that was working on the hall.2. On 01/27/2026 at 11:11 A.M. of Resident #51's room revealed the bed sheets and covers have dried brown spots, appear to be dried blood. Resident #51 stated he does not know when they change his sheets he is not in the room.On 1/29/26 at 2:39 P.M. interview with CNA #921 revealed she had been in Resident #51's room and asked him if he needs anything, but he will ring if he needs anything. CNA #921 stated linens get changed on bath days and when needed.On 01/28/2026 at 2:47 P.M. observation of Resident #51 bed sheets with CNA #920 verified small amount of smeared BM on the chuck, and multiple blood spots from Resident #51 scratching himself, also other brown areas on his flat sheet, top sheet and covers. CNA #920 stated his sheet did need to be changed and she had not noticed it during her shift.3. Interview on 01/27/2026 at10:22 A.M. with Resident #172 revealed he had been in the room for about a week. Observation of his room at that time revealed the night light on wall is loose and the electric baseboard was in disarray. The front panel of the electric heater was off at one end, and the coils appeared to be bent. Observation on 01/29/2026 at 8:40 A.M. of Resident #172's room with Maintenance Assistance #874 verified the night light on the wall was loose and the baseboard heater beside the bed was in disarray. The front panel was coming off the front of the heater and was caught on Resident #172's rollator and the coils were bent. Review of the facility Resident Handbook on page 47 revealed resident has a right to a safe, clean, comfortable and homelike environment. Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior and clean bed and bath linens that are in good condition.This deficiency represents non-compliance invsetigated under Complaint 2685934.

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	365289	A. Building B. Wing	01/29/2026

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 reviews, interviews and observations the facility failed to assist Resident #32 with his meal per his care plan. This affected one resident (Resident #32) of one residents reviewed for meal assistance. The census was 162.Findings include: Review of the medical record for Resident #32 revealed an admission date of 09/12/24. Diagnoses included dementia, depression, anxiety, hypertension, need for assistance with personal care and muscle weakness. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #32 was cognitively impaired. He required set-up or clean-up assistance with eating. He was dependent for all other activities of daily living. Review of the medical nutritional assessment dated [DATE] revealed Resident #32 weighed 169.8 pounds. He ate 50-100% of meals. He was ordered a house supplement BID. Review of January 2026 orders revealed Resident #32 had an order for regular diet and thin liquids and a 4 ounce house supplement twice a day. Review of monthly weights revealed Resident #32 weighed 167.9 pounds on 11/07/25 and 161.4 on 01/06/26. Review of the care plan initiated on 09/13/24 revealed Resident #32 was at risk for decreased nutritional status and dehydration. Interventions included assisting him with meals and feeding as necessary which was initiated on 09/13/24 and revised on 01/28/26 during the survey after observations by surveyor. Other interventions included monitoring intakes and weight. Interview on 01/27/26 at 3:03 P.M. with Resident #32's daughter revealed the resident needed cued for eating. She stated when she was there for meals, she would put food in his hand and he would eat every time. She was concerned about weight loss. She believed the facility had a plan in place after she mentioned issue to them recently. Observation on 01/28/26 at 12:04 P.M. of the Memory Care Unit (MCU) dining room, where Resident #32 resided, revealed two certified nursing assistants (CNAs) #912 and #937, Activity Director (AD) #817 and Human Resources (HR) #819 passing lunch. Observation on 01/28/26 at 12:06 P.M. revealed Resident #32 was seated at the table. AD #817 was assisting Resident #83 across the table. At 12:10 P.M. AD #817 and HR #819 were speaking across the table to each other while Resident #32's meal was placed in front of him. HR #819 stated she thought that he would eat it if staff handed him the food or utensil AD #817 responded I don't think so stating he would eat it if placed in front of him. HR #819 did hand him a sandwich and he started eating it. HR #819 left the dining room and did not return. AD #817 continued to help Resident #83 across the table from Resident #32. At 12:15 P.M. Resident #32 tried to open up his packet of crackers including biting the wrapper which took him five minutes to do. At 12:21 P.M. Resident #32 was done eating his crackers. He still had a bowl of soup, potato salad and fruit, all of which were untouched. AD #817 gave a verbal cue to him from across the table however he did not attempt to pick up spoon or fork. AD #817 was still assisting other resident. At 12:28 P.M. Resident #32 closed his eyes. At 12:35 P.M., with his eyes still closed, he tried to push back from the table but the front of the chair just lifted in the air then back down. Resident #32's nose was dripping. At 12:36 P.M., CNA #912 asked him if he was done and he mumbled something. CNA #912 gathered his untouched food and removed it from the table. Interview on 01/28/26 at 12:50 P.M. with CNA #912 revealed Resident #32 usually ate independently, they monitored his meal intakes, did not write the meal intake down, but documented what she remembered. CNA #912 revealed Resident #32 ate 50% of his meal today. Interview on 01/29/26 at 9:34 A.M. with AD #817 revealed nursing staff kept her well-informed on who needed assistance. She revealed Resident #32 needed verbal cues but said it depended on the day. AD #817 revealed the resident was not a big eater but could not rule out that he was not eating as a result of not remembering to eat. Interview on 01/29/26 at 10:27 A.M. with Registered Nursing (RN) #950 revealed Resident #32's daughter was active in his care. She stated he ate well on some days but other days he did not. She stated her expectation was to allow him to try to eat on his own and assist him before taking away food. Interview on 01/29/26 at 2:34 P.M. with Director of Nursing (DON) revealed there was no specific policy for activities of daily living. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She also verified Resident #32's care plan had an intervention of assisting with meals and to feed resident as needed which was initiated on 09/13/24 and then had a revision date of 01/28/26. Interview on 01/29/26 at 3:30 P.M. with HR #819 revealed she helped pass trays at least once a week as part of facility program. She was a CNA for 25 years. She had seen a CNA place food in Resident #32's hand and saw that it worked for him to start eating. She also stated she knew from experience to try different cues with residents with cognitive impairment. This deficiency represents non-compliance investigated under Complaint 2653004.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews the facility failed to ensure resident's received timely assistance to meet their needs. This affected two of two residents (Resident #180 and Resident #181) observed for call lights. The facility census was 162. Findings Include:Observation on 01/28/26 at 11:25 A.M. of the call light monitor on the 500-hall nurse's station revealed Certified Nurse Assistant (CNA) #909 was seating at the desk charting on the computer right next to the call light monitor. CNA #909 then got up and stated she had to answer the call lights. Call lights for room [ROOM NUMBER] (Resident #181) had been on for 34:54 minutes and room [ROOM NUMBER] (Resident #180) call light had been on for 43 minutes. This was verified with Licensed Practical Nurse (LPN) #971.Interview with Register Nurse (RN) #821 on 01/28/26 at11:29 A.M. revealed CNA #884 was on the hall and should have answered the call light. RN #821 verified 35 minutes was too long. RN #821 revealed Resident #181 used the call light frequently.Interview on 01/28/26 at 11:38 A.M. with LPN #902 revealed her pager was on the desk in the nurses station and did not have a chance to check the pager to see if there was a call light that needed answered because she was doing passing medication. LPN #902 revealed when she is not passing medications she will look at her pager and answer call lights.Interview on 01/29/26 at 11:48 A.M. with Resident #180 revealed he had his light on for a very long time because he could not reach his water and his personnel items because the side table was too far away. Resident #180 stated his call light is not answered timely.Interview on 01/29/26 at 11:50 A.M. with CNA #942 revealed she had four residents that needed to get up for therapy and was making her way to Resident #180. CNA #942 stated call lights need to be answered as soon as they can. Interview on 01/29/26 at 11:55 A.M. with CNA #909 revealed she was sitting at the 500-hall nurses station charting and seen on the call light monitor that two call lights need to be answered. She stated she was trying to get some charting completed before she went home and had been sitting there for about five minutes. CNA #909 stated she should have got up and answered the call lights for room [ROOM NUMBER] and 610 due to they had been on for more than 35 minutes.Interview on 01/28/26 at 11:56 A.M. with RN #821 verified 43 minutes was to long for a resident to wait to get their call light answered.

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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 interview and record review the facility failed to ensure Resident #110 was assessed properly after they returned to the facility from the dialysis center. This affected one resident sampled for dialysis care. The facility census was 162.Findings include:Review of the medical record revealed Resident #110 was admitted to the facility on [DATE] with diagnoses that included traumatic brain injury, diabetes type two, kidney disease, nephritic syndrome (inflammation of the filtering units of the kidneys), and need for assistance with personal care.Review of the physician orders revealed an order dated 10/02/25 that Resident #110 received dialysis at an outside dialysis center every Tuesday, Thursday, and Saturday and the absence of an order to assess the resident on return from the dialysis center.Review of the care plan revealed a revision dated 10/03/25 that Resident #110 received dialysis with the goal of being free from complications related to dialysis and an intervention dated 09/12/25 to monitor vital signs as needed.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #110 was cognitively intact, did not reject care, was independent for most activities of daily living, and received dialysis care.Review of the progress notes from 11/29/25 to 01/28/26 revealed the absence of a post dialysis assessment on 01/27/26, 01/24/26, 01/20/26, 01/17/26, 01/15/26, 01/13/26, 01/10/26, 01/08/26, 01/04/26, 01/02/26, 12/28/25, 12/23/25, 12/16/25, 12/13/25, 12/11/25, 12/06/25, 12/04/25, and 12/02/25; and no evidence that Resident #110 refused a post dialysis assessment.An interview on 01/29/26 at 8:52 A.M. with Licensed Practical Nurse (LPN) #911 revealed they would expect an assessment to be completed when Resident #110 returned from dialysis.An interview on 01/29/26 at 8:57 A.M. with LPN #911 verified the absence of post dialysis assessments in the dialysis communication binder.An interview on 01/29/26 at 12:55 P.M. with the Director of Nursing (DON) revealed the facility does not complete post dialysis assessments.Review of the facility policy titled Dialysis Policy, dated 04/2022 revealed the facility will provide appropriate treatments related to dialysis care and that licensed nursing staff will notify the physician and dialysis center of any abnormal findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review and policy review, the facility failed to ensure enhanced barrier precautions were followed while providing Resident #181 catheter care. This affected one resident (Resident #181) of one resident reviewed for catheter care. Findings include:Review of the medical record for Resident #181 revealed an diagnosis of neurogenic bladder. Orders for indwelling catheter, and on Enhanced Barrier Precautions.Observation of Resident #181's door revealed Resident #181 was on Enhanced Barrier Precautions (EBP) and gown and gloves were to be worn while providing urinary catheter care.Observation on 01/28/2026 3:34 P.M. of Resident #181 indwelling catheter care with Certified Nursing Assistant (CNA) #884 revealed Resident #181 had a sign outside the door stating she was on EBP and a gown and gloves were to be worn while providing catheter care. Observation of CNA #884 revealed she did not wear proper Personal Protection Equipment while providing indwelling catheter care. Interview on 01/28/2026 at 3:42 P.M. with Resident #181 stated staff never wear a gown when providing catheter care.Interview on 01/28/2026 3:47 P.M. with CNA #884 verified Resident #181 was on EBP and she should have worn a gown while providing catheter care. CNA #884 stated she asked prior to completing catheter care and was told she did not need to wear a gown.Review of the facility policy Catheter Care Policy, dated 09/2023 revealed wash hands and don gloves. There was no mention of EBP need to be taken during catheter care.