STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365292	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hanover Healthcare Center	435 Avis 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews and policy review, the facility failed to ensure its kitchen area was maintained in a clean and sanitary condition. This had the potential to affect 118 out of 119 residents who consumed meals from the facility's kitchen, as one resident (Resident #44) out of 119 residents received nothing by mouth. The census was 119.Findings include:Tour of the kitchen on 03/09/26 from 6:06 A.M. to 6:25 A.M. revealed in the prep area the microwave had dried food inside and the table it sat on was dirty with food crumbs. The shelf underneath had rice Krispies, cheerios, corn flakes, and frosted flakes in containers that were not dated. The reach-in refrigerator had five rusty shelves with shredded cheese not labeled or dated and butter that was in a one sixth hotel pan that was not wrapped properly, labeled or dated. The serving area had grease on the table where the toaster was placed. The plate warmer and pellet warmer had food splatter on them. The steam table had dried food on seven out of ten steam table wells with five lids dirty with dried food and gravy. The dish area had cracked [NAME] floor tiles. The clean area of the drain board of the dish machine had dried food and a salt packet on it. In the cooking area, the slicer had dried meat on it near the blade, the robot coupe had dried food around the base of the machine. There were cracked tiles and a hole in the wall where the food carts were stored. This was verified by [NAME] #575 on 03/11/26 at 6:25 A.M.Observation on 03/10/26 at 10:43 A.M. revealed [NAME] #536 rinsed out the robot coupe in the three-compartment sink without the proper washing and sanitizing process and revealed she only rinses it out.Review of the policy entitled Operation and Sanitation dated 05/20/20 revealed operating instructions and cleaning procedures are developed for all dining services equipment.Review of the closing checklist revealed that all equipment should be cleaned, and all food is wrapped, labeled and dated.This deficiency represents non-compliance investigated under Complaint Number 2746141.

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to prevent a fall while using a mechanical lift for Resident #123 and failed to ensure smoking interventions were followed for Residents #105 and #127. This affected one resident (Resident #123) of five residents reviewed for falls and affected two residents (Resident #105 and Resident #127) of four residents reviewed for smoking. The facility census was 113.Findings include: 1. Review of the medical record for Resident #123 revealed she was admitted to the facility on [DATE] with diagnoses that included right foot fracture, morbid obesity, back pain, diabetes mellitus type 2, and bipolar disorder. She was discharged from the facility on 07/11/25. Review of the care plan dated 05/03/25 revealed Resident #123 was at risk for falls related to impaired mobility, morbid obesity, and the mechanical lift tipped over interventions included to provide assistive devices as needed. Review of the Fall Risk Observation tool dated 05/20/25 at 6:33 A.M. revealed Resident #123 was at risk for falls and was a total mechanical lift for all transfers. Review of the progress note dated 05/22/25 at 3:10 P.M. revealed the mechanical lift tipped over while Resident #123 was being transferred from the bed to a stretcher for an orthopedic follow-up appointment. Review of the fall investigation dated 05/22/25 at 3:10 P.M. revealed Resident #123 fell to the floor while still connected to the mechanical lift. Review of the witness statement from Certified Nurse Aid (CNA) #612 dated 05/22/25 at 3:10 P.M. revealed that when Resident #123 was transferred with the mechanical lift it lost balance while turning and tipped over, Resident #123 had to be lifted from the floor. Review of the discharge Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #123 was cognitively intact, did not reject care, required maximal assistance for transfers, and had fallen while admitted to the facility. An interview on 03/16/2026 at 10:59 A.M. with CNA #612 verified that Resident #123 had fallen while being transferred using a mechanical lift. Review of the undated policy titled Mechanical Lift and Transfers revealed the facility would meet the psychosocial, physical, and emotional needs of residents and safety is a primary concern. 2. Review of the medical record for Resident #127 revealed he was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (lung disease), respiratory failure, heart disease, and amputation of the right hand. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #127 did not have sensory deficits, was cognitively intact, required setup assistance for eating and oral hygiene, and was dependent on staff for dressing, transferring, and bathing. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the smoking assessment dated [DATE] at 4:38 P.M. revealed Resident #127 was a supervised smoker that required a smoking apron due to a dexterity problem. An interview on 03/11/26 at 4:00 P.M. with Resident #127 revealed during his last smoking time staff did not provide a smoking apron. An interview on 03/11/26 at 4:38 P.M. with CNA #608 verified she did not put a smoking apron on Resident #127 on that smoking time. Review of the undated smoking policy titled Resident Smoking Guidelines, revealed the facility was to promote resident centered care, a safe smoking area for supervised smokers, and staff were to monitor supervised smokers. 3. Review of Resident #105's medical record revealed admission date 02/07/23 with diagnoses including but not limited dementia, traumatic amputation at right and left elbows with use of prosthesis, Chronic Obstructive Pulmonary Disease (COPD), and nicotine. Review of Resident #105's smoking care plan dated 11/26/25 revealed Resident #105 uses a smoking apron and is a supervised smoker. Review of Resident #105's annual MDS dated [DATE] revealed Resident #105 was cognitively intact with a Brief Interview Mental Status (BIMS) score of 14 out of possible 15 and required assistance from staff for completion of Activities of Daily Living (ADL) tasks. Review of Resident #105's smoking assessment dated [DATE] revealed Resident #105 requires adaptive equipment, one on one supervision, and to wear a smoking apron (a fire-resistant apron used to cover the torso or body and lap to aid in preventing cigarette ashes or dropped cigarettes from igniting clothing). Observation on 03/09/26 at 11:10 A.M. revealed Resident #105 sitting in his wheelchair in the smoking area with CNA #564 passing out cigarettes and assisting resident with lighting of their cigarettes. Resident #105 began smoking his cigarette without having a smoking apron in place, Resident #105 was observed scrapping the cigarette ashes off the end of his cigarette by using his left prosthesis with the ash falling on his lap and upper thighs. Interview on 03/09/26 at 11:25 A.M. with CNA #564 confirmed Resident #105 did not use a smoking apron while he was smoking a cigarette. CNA #564 stated she didn't know of anyone needing to use a smoking apron while smoking. Review of the facility policy titled Resident Smoking Guidelines undated revealed a Smoking Apron is a fire-resistant apron used to cover the torso or body and lap to aid in preventing cigarette ashes or dropped cigarettes from igniting clothing. It is the policy of this facility to promote resident centered care by providing a safe smoking area for residents that request to smoke and are capable of safe smoking behaviors either independently or with supervision. This deficiency represents non-compliance investigated under Complaint Number 2746141 and 2726816.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, facility policy review, equipment and resident observations, and resident and staff interviews the facility failed to ensure appropriate respiratory care was provided for Residents #6, #12, #44, and #126. The affected four residents (Residents #6, #12, #44, and #126) of five residents reviewed for respiratory care. The facility census was 125. Findings Include: 1. Review of the medical record for Resident #126 revealed admission to the facility on [DATE] with diagnoses including acute respiratory failure, lung disease, bipolar disorder (a mood disorder leading to periods of depression and mania), depression, anxiety, smoker, diabetes, heart failure, end stage renal disease with hemodialysis, and fibromyalgia (chronic generalized pain). Further review of the medical record for Resident #126 revealed a brief interview for mental status completed on 03/04/26 with a score of 15/15, indicating that Resident #126 was cognitively intact. Review of the medical record for Resident #126 revealed an order provided by the primary care physician (PCP) #651 dated 03/04/26 for Resident #126 to have oxygen at 1-4 liter(L)/min(M) via nasal canula continuously. There were no parameters listed on the order to indicate when to adjust the oxygen flow rate from 1 L/M to 4 L/M. Further review of the medical record for Resident #126 revealed pulse oximeter readings from 03/09/26 through 03/17/26 indicating oxygen levels between 90% to 99% on room air without oxygen use. Interview on 03/17/26 at 11:56 A.M. with the clinical manager, Registered Nurse (RN) #526 confirmed there were no parameters for oxygen adjustment for Resident #126. Interview on 03/17/26 at 11:56 A.M. with RN #526 revealed that the facility does not have standing orders for oxygen parameters to adjust oxygen flow of residents. RN #526 revealed she would use her clinical judgement to adjust the oxygen flow from 1-4 L/M to keep the average resident's oxygen level greater than 92% based on pulse oximeter readings. RN #526 further reported she would adjust oxygen flow for residents with history of chronic lung disease if the oxygen level greater than 90%. RN #526 also admits that staff do not always request parameter clarification orders from the providers. She further revealed that Resident #126 was not always compliant with wearing her ordered oxygen. RN #526 verified that all entries on the pulse oximeter log from 03/09/26 through 03/17/26 indicated that Resident #126 was not wearing oxygen as prescribed and was on room air. Observation and interview on 03/17/26 at 12:11 A.M. with Resident #126 revealed resident had been transferred to a new room on 03/16/26 and now in a private room on the second floor resting in bed without oxygen on. No acute respiratory distress noted. Resident #126 denied shortness of breath at that time. Resident #126 further revealed that she does not always wear her oxygen and only when she feels she needs it. Resident #126 reported that the facility staff do check her oxygen levels with the pulse oximeter frequently. Further observation revealed no oxygen equipment in the room and Resident #126 reported the staff were supposed to be bringing it up to her new room. Continued observation revealed that Resident #126 required assistance of two persons to set on side of bed for lunch meal and transfers. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/17/26 at 12:25 P.M. with Licensed Practical Nurse (LPN) #504 revealed Resident #126 had been transferred to new room yesterday. LPN #504 verified that there was no oxygen equipment in Resident #126 room and that it must have gotten left at dialysis yesterday evening. LPN #504 reported she would find oxygen equipment and provide it to Resident #126. LPN #504 reported that she was not aware of any oxygen parameters to determine when to adjust oxygen levels from 1-4 L/M. She continued to report that she would adjust oxygen levels based on nursing assessment of lung sounds and if resident was displaying respiratory distress such as shortness of breath. LPN #504 further reported that she would notify a medical provider if a resident's oxygen level went below 92% but did not recall a specific facility parameter to notify medical providers of low oxygen levels. LPN #504 also indicated that Resident #126 now required the use of a manual lift and staff assistance for transfers and mobility. Review of the facility policy for medical oxygen use undated revealed no guidance related to range orders oxygen flow or parameters for adjusting oxygen liter flow. 2. Review of the medical record for Resident #12 revealed she was admitted to the facility on [DATE] with diagnosis that included obstructive sleep apnea, heart failure, muscle weakness, and morbid obesity. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #12 was able to understand and be understood, had adequate vision with glasses, was cognitively intact, did not reject care, was dependent on staff for most activities of daily living, and utilized a non-invasive mechanical ventilator (a respiratory support device that uses positive pressure to assist breathing) such as a continuous positive airway pressure (CPAP) machine (a machine used to help treat sleep apnea. Review of the physician orders revealed an order dated 12/09/2025 for a CPAP with a full-face mask every night for obstructive sleep apnea (OSA) and the absence of orders to clean the CPAP machine, face mask, or tubing. Review of the care plan dated 01/07/26 revealed Resident #12 had sleep apnea and required a noninvasive mechanical ventilation at night related to sleep apnea with a goal to verbalize less difficulty breathing. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) from 02/01/2026 to 03/16/26 revealed the absence of documentation for cleaning the CPAP machine or checking it was in working order. An interview on 03/09/26 at 8:40 A.M. with Resident #12 revealed she had a broken CPAP machine and that she had reported it multiple weeks prior. An interview on 03/09/26 at 9:15 A.M. with Registered Nurse (RN) #655 verified Resident #12's CPAP was not in working order. An interview on 03/17/26 at 11:57 A.M. with Licensed Practical Nurse (LPN) #526 revealed there was to be a physician order to clean CPAP machines weekly and that cleaning was to be documented on the TAR. LPN #526 verified the absence of a physician order to clean Resident #12's CPAP and the absence of cleaning in the TAR. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the undated facility policy titled APaP, BiPaP, CPaP, VPaP, Cleaning and Maintenance, revealed the facility was to provide resident centered care that meets needs of the residents, safety is a primary concern, CPAP's required thorough cleaning, machines were to be cleaned at least once per week, and parts were to be visually inspected for deterioration. 3. Review of Resident #44's medical record revealed admission date 02/27/26 with diagnoses including but not limited to acute respiratory failure, epilepsy, kidney failure requiring hemodialysis, tracheostomy, and gastrostomy. Review of Resident #44's physician orders revealed an order dated 03/04/26 for tracheostomy care every shift, an order dated 03/12/26 for cool air mist via trach collar every shift with oxygen titrated at 6 liters, and an order dated 03/12/26 at 3:06 P.M. to check level of humidification bottle and refill if needed, every 4 hours. Review of Resident #44's care plan dated 03/06/26 revealed tracheostomy using Shiley (type of tracheostomy) size six extra large with humidified air via trach collar. Observation on 03/12/26 at 2:20 P.M. revealed Resident #44 laying in bed with trach collar in place with oxygen set at six liters, the trach collar tubing was attached to an empty humidifier bottle. Registered Nurse (RN) #526 performed trach care for Resident #44 including suctioning Resident #44's trach several times due to increased phlegm. RN #526 replaced the trach collar which was still attached to the empty humidifier bottle. Interview on 03/12/26 at 2:42 P.M. with RN #526 confirmed Resident #44's humidifier bottle was empty of distilled water. RN #526 stated when there's no humidified air being delivered via a trach collar Resident #44 will have increased phlegm production and the nurses should be monitoring the humidifier bottle for appropriate water level. 4. Review of the medical record for Resident #6 revealed orders dated 06/12/26 to perform trach care every shift and as needed. Review of the medical record for Resident #6 revealed orders dated 06/13/26 to replace inner cannula during trach care every day. Review of the medical record for Resident #6 revealed orders dated 06/25/25 to have the same sized trach (endotracheal tube or ETT) and one sized smaller at bedside at all times. Review of the medical record for Resident #6 revealed orders dated 11/21/25 for the resident to have 5XL cuffed Shiley endotracheal tube (ETT). On 03/10/26 at 8:40 A.M., an observation of Resident #6 room failed to reveal a 5XL cuffed Shiley ETT. There was one 5XL cuffless Shiley noted. There were no smaller ETT in the room. The humidifier for the oxygen was noted to have been changed 02/25/26, 13 days prior. These observations and the resident's physician orders for trach care were confirmed by Licensed Practical Nurse (LPN) #642 on 03/10/26 at 8:55 A.M. On 03/10/26 at 8:45 A.M., an interview with Resident #6 revealed he had a difficult time getting any supplies from the facility. He reported he had to do all of his endotracheal care on his own because he got an infection in the past and he did not think the staff understood how to care for his ETT. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/10/26 at 8:55 A.M., an interview with LPN #642 confirmed the resident did not have the needed supplies in his room. She reported they could not get supplies or smaller ETT, and she thought the 5XL Shiley cuffless was what had been ordered, but confirmed the order read for a cuffed 5XL Shiley. LPN #642 also confirmed the humidifier had not been changed since 02/25/26. She reported she could not confirm when the last time had been since she had observed the resident's tracheotomy area or change the dressing. She had educated him about cleanliness, but had not done the ETT care as ordered.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, taste test and recipe review, the facility failed to serve pureed foods at a smooth consistency for safe swallowing. This had the potential to affect six residents (#4, #15, #66, #73, #77, and #104) who were prescribed pureed diets of 118 residents who consumed meals from the facility's kitchen.Findings include:Interview on 03/09/2026 at 8:20 A.M. with Resident #15 revealed the food tastes bad and the texture was not correct and sometimes the pureed food could be consumed through a straw.Observation of puree preparation on 03/10/26 at 10:56 A.M. with [NAME] #536 pureeing pasta revealed [NAME] #536 pureed pasta then put it in a one third hotel pan and stated that she was done with pureeing the pasta. The pasta had chunks of pasta in it. Regional Dietary Manager (RDM) #900 tasted the pureed pasta and verified that the puree pasta had chunks in it. [NAME] #536 had to puree the pasta more.Review of the undated pureed pasta recipe revealed that the pasta should be put in a processor and blend until smooth. Observation of the lunch try line on 03/11/26 from 11:15 A.M. through 12:45 P.M. revealed that the food was on the steam table and tray line started. Observation on 03/11/26 at 11:26 A.M. of the pureed ham revealed that there were dark chunks in it. Dietary Manager (DM) #531 tasted the pureed ham and verified that the puree ham had chunks in it. DM #531 stopped the try line to puree the ham.Review of the undated pureed ham recipe revealed that the ham should be put in a processor and blend until smooth.

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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 observation, interview and record review, the facility failed to provide a safe, clean, comfortable homelike environment for all residents. This affected three residents (#6, #45, and #85) reviewed for environment. The facility census was 113. Findings include:1. On 03/09/26 at 7:30 A.M., an observation of Resident #45 in bed. Observation of the room revealed disarray and smelled of urine. He had dirty clothes on a chair with clean linen on top. There were soiled underwear in the corner and trash on the floor. His bed controller was on the floor at the foot of the bed, out of his reach. On 03/09/26 at 7:40 A.M., an interview with the Director of Nursing (DON) confirmed the urine smell in Resident #45's room, as well as dirty linens, dirty clothes, trash, and general disarray of the room. 2. On 03/10/26 at 8:40 A.M., an observation of Resident #6's room revealed the sheets at the head of the bed were soiled with dark substance. The medical equipment, which included two suction machines and an oxygen concentrator were splashed with dark substances, and the canister of one of the suction machines had fluid in it. The top of the refrigerator had a layer of dust on it. The inside of the refrigerator had sticky substances covering most of the surfaces of the refrigerator. On 03/10/26 at 8:41 A.M., an interview with Resident #6 revealed most of the time he changed his own sheets if they were changed. He indicated he had asked for his clothing to be washed for over a week and this had not been done. He was down to his last clean shirt and pair of pants (which were visibly soiled), and his dirty clothes were stacked up in his closet. On 03/10/26 at 9:00 A.M., an interview with Licensed Practical Nurse (LPN) #642 verified the observations of Resident #6's room. LPN #642 stated the resident had asked her to get his clothing washed and she had not had a chance to let anyone know. She indicated the certified nurse aides (CNA) changed the resident room linens, and she was not sure who was responsible for making sure the medical equipment was clean. On 03/10/26 at 9:05 A.M., an interview with housekeeper (HK) #571 revealed she had cleaned Resident #6's room about one hour before. She indicated housekeeping cleaned the floors, dusted the surfaces of cabinets, dressers, and refrigerators, and on deep cleaning days, they would change the privacy curtains of the rooms. HK #571 stated CNAs were responsible for changing bed linens, but she was not sure who was supposed to clean the medical equipment. 3. On 03/09/26 at 1:24 P.M., an interview with Resident #85 revealed she had fallen twice in the bathroom a couple weeks ago due to toilet seat not being attached to the toilet. She stated a work order was put in for it to be fixed. She also stated the toilet would not flush and she had to use a plunger every time. In addition, she said the sink leaked onto the floor because the pipe just hung down under the sink. On 03/09/26 at 1:40 P.M., an observation Resident #85's bathroom revealed a toilet with a loose set that slid to the side when pressure was placed on the hand rails over the toilet seat. This was confirmed by DON at the time of the observation. This deficiency represents non-compliance investigated under Complaint Number 2726816 and 2691714.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review the facility failed to updated Preadmission Screening and Resident Reviews (PASRR) when residents had a change in condition. This deficient practice affected two residents (Resident #10 and #85) out of five residents reviewed for PASRR. The facility's census was 113. Findings Include:1. Review of Resident #10's medical record revealed an admission [DATE] with diagnoses including but not limited to schizoaffective disorder, anxiety, bipolar disorder, and major depressive disorder.Review of Resident #10's physician orders revealed an order dated 04/08/25 for antipsychotic medication Seroquel oral tablet 50 milligram (MG) give one tablet by mouth two times a day for schizoaffective disorder and an order dated 04/08/25 for Depakote oral capsule 125 MG give two capsules by mouth two times a day for bipolar disorder.Review of Resident #10's PASRR dated 05/05/2017 revealed there was no antipsychotic medication marked for Resident #10.Interview on 03/12/26 at 3:39 P.M. with Social Services #557 confirmed Resident #10's PASRR was not updated to reflect the use of antipsychotic medications.2. Review of the medical record for Resident #85 revealed admission [DATE] with diagnoses including but not limited to psychotic disorder with delusions (04/25/25), dementia with psychotic disturbance, major depression disorder (04/25/25) and anxiety.Review of Resident #85's PASRR dated 11/25/25 revealed panic or other Severe Anxiety Disorder was marked as the only diagnosis.Interview on 03/12/26 at 3:50 P.M. with Social Services #557 confirmed Resident #85 did not have an updated PASRR reflecting the diagnoses of psychotic disorder with delusions and major depression disorder.Review of the facility policy titled PASRR - Pre-admission Screening and Resident Review undated PASRR can also advance person-centered care planning by assuring that psychological, psychiatric, and functional needs are considered along with personal goals and preferences in planning long-term care.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, facility policy review, and staff interviews the facility failed to provide a written baseline care plan to Residents #125 and Residents #126. The affected two residents (Resident #125 and Resident #126) of two residents reviewed for new admissions to facility in less than 14 days. The facility census was 125.Findings Include:1.Review of the medical record of Resident #125 revealed admission to facility on 03/06/26 with diagnoses including aftercare for surgical amputation of the left leg above the knee, heart failure, high blood pressure, end stage renal disease with dialysis, atrial fibrillation (irregular heart rate), lung disease, anxiety, gastric reflux, and delirium (confusion).Further review of the medical record for Resident #125 revealed a brief interview for mental status completed on 03/06/26 with a score of 08/15, indicating that Resident #125 had moderate cognitive impairment (forgetfulness).Observation on 03/17/26 at 10:27 A.M. of Resident #125 revealed Resident #125 smiling and pleasantly confused in no acute distress and denied pain. Review of the medical record for Resident #125 revealed a care conference note dated 03/10/26 at 12:30 PM authored by Licensed Social Worker (LSW) #557 indicating resident #125, daughter of resident #125, speech therapist, an aide, and LSW were present for the care conference. There was a section that reads: Review of Care Plan: Daughter [NAME] here. She shared living will and medical power of attorney documents. Discharge plan is to go home where he lives with daughter. Daughter is eager to see him gain strength through therapy. There was no evidence in the medical record that the baseline care plan was provided in writing to Resident #125 or his daughter within 48 hours.Further review of the medical record revealed a Nursing admission Evaluation-V 13 completed and signed on 03/06/026 by the Director of Nursing (DON). The Nursing admission Evaluation included initial care planning areas needing addressed and immediate interventions established. It was also noted on page 18 or 19 for the care plan signature page to be printed and all signatures be obtained and the page to uploaded to electronic the medical record. Interview on 03/16/26 11:42 A.M. with the Director of Nursing (DON) revealed that the interdisciplinary team (IDT) meets within 72 hours (3 days) of resident admission to facility and discusses the care plan for each new resident. The team includes nursing, dietary, therapy, speech, activities and the social worker. The DON verified that the Nursing admission Evaluation-V 13 includes the baseline care plan embedded within the assessment. The DON also verified that there was to be a signature page printed off and signed and uploaded to the electronic medical record. The DON revealed he was unaware of the regulation of a baseline care plan being completed within 48 hours and a copy being given to the residents/representative. Interview on 03/16/26 at 3:30 P.M. with the DON revealed confirmation that there was no evidence that a care plan was provided to Residents #125 within 48 hours.Review of the facility policy undated and titled Baseline Care Plan/ 48 Hour Care Plan, revealed the baseline care plan will be printed and shared with the resident or resident representative and once all signatures are affixed, the care plan signature page will be uploaded into the electronic medical record.2. Review of the medical record for Resident #126 revealed admission to the facility on [DATE] with diagnoses including acute respiratory failure, lung disease, bipolar disorder (a mood disorder leading to periods of depression and mania), depression, anxiety, smoker, diabetes, heart failure, end stage renal disease with hemodialysis, and fibromyalgia (chronic generalized pain).Further review of the medical record for Resident #126 revealed a brief interview for mental status completed on 03/04/26 with a score of 15/15, indicating that Resident #126 was cognitively intact.Review of the medical record revealed a Nursing admission Evaluation-V 13 started on 03/04/026 and completed and signed on 03/08/26. The Nursing admission Evaluation included initial care planning areas needing addressed and immediate interventions established. It was also noted on page 18 or 19 for the care plan signature page was to be printed and all signatures be obtained and then the page was to be uploaded to electronic the (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical record.Interview on 03/16/26 11:42 A.M. with the DON revealed that the interdisciplinary team (IDT) meets within 72 hours (3 days) of resident admission to facility and discusses the care plan for each new resident. The team includes nursing, dietary, therapy, speech, activities and the social worker. The DON verified that the Nursing admission Evaluation-V 13 includes the baseline care plan embedded within the assessment. The DON also verified that there was to be a signature page printed off and signed and uploaded to the electronic medical record. The DON revealed he was unaware of the regulation of a baseline care plan being completed within 48 hours and a copy being given to the residents/representative. Interview on 03/16/26 at 3:30 P.M. with the DON revealed confirmation that there was no evidence that a care plan was provided to Resident #126 within 48 hours.Review of the facility policy undated and titled Baseline Care Plan/ 48 Hour Care Plan, revealed the baseline care plan will be printed and shared with the resident or resident representative and once all signatures are affixed, the care plan signature page will be uploaded into the electronic medical record.

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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 review, observation, interview and facility policy review the facility failed to accommodate a resident with prosthetic arms which required assistive devices for self-feeding. This deficient practice affected one resident (Resident #105) out of one resident reviewed for activities of daily living. The facility census was 113. Findings Include:Review of Resident #105 medical record revealed admission date 02/07/23 with diagnoses including but not limited to dementia, traumatic amputation at right and left elbows, and Chronic Obstructive Pulmonary Disease (COPD).Review of Resident #105's annual Minimum Data Set (MDS) dated [DATE] revealed Resident #105 was cognitively intact with a Brief Interview Mental Status (BIMS) score of 14 out of possible 15 and required staff assistance with setting up for eating.Review of Resident #105's physician orders revealed an order dated 01/15/26 for bilateral upper arm prosthetic device on prior to breakfast and off immediately after dinner meal, as tolerated. Check skin integrity before application and after removal every shift.Review of Resident #105's Occupational Therapy (OT) service notes dated 12/03/25 to 02/06/26 revealed OT discharge recommendations for self-feeding including stand-by-assist by staff and use of a scoop plate.Observation on 03/09/26 from 7:30 A.M. to 8:05 A.M. revealed Resident #105 sitting at the dining room table with bilateral upper arm prosthesis, with bilateral grabber hooks, in place. Breakfast meal was served consisting of French toast and cold cereal with milk, cup of coffee and cup of milk with straws for use by Resident #105. On the bilateral upper arm prosthetics there were red and white colored plastic utensils attached to the prosthesis by loose fitting straps. Resident #105 pushed both plastic utensils up each of the prosthesis, out of the way of the grabber hooks. Resident #105 then bent over the plate of French taste and started eating without using any type utensil, scooping the food up with his mouth. Activities Assistant #605 approached Resident #105's table and encouraged him to use the utensils hanging from the prosthetic arms. Resident #105 continued to scoop food from the plate with his mouth.Observation on 03/10/26 at 7:50 A.M. revealed Resident #105 sitting at the dining room table eating breakfast meal using a regular spoon to eat cold cereal with milk. Resident #105 then put the spoon down, bent over the plate and started eating scrambled eggs by scooping them up with his mouth and not using utensils. Staff did not come over to assist Resident #105 or encourage him to use a fork. Interview on 03/12/26 at 1:15 P.M. with Therapy Director #601 revealed the red and white utensils are to be used when Resident #105 does not have the prosthesis on. Resident #105 prefers to use thin handled utensils and can hold the utensils with the grabber hooks on the prosthesis.Interview on 03/12/26 at 3:05 P.M. with Certified Nursing Assistant (CNA) #564 confirmed Resident #105 does not use utensils to eat with and prefers to scoop the food up with his mouth. CNA #564 stated it appears easier for Resident #105 to not use utensils and just eat the food right off the plate. CNA #564 stated Resident #105 has to be encouraged to use a spoon or fork daily.Reviewed the facility's policy titled Routine Resident Care undated revealed provide routine daily care by a certified nursing assistant under the supervision of a licensed nurse, routine care by a nursing assistant includes but not limited to the following, assisting or provides for personal care, eating and hydration.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide individualized activities of interest to Resident #18. This affected one resident (Resident #18) out of three residents reviewed for activities.Findings include:Review of the medical record for Resident #18 revealed an admission date of 09/15/27 with diagnoses to include Alzheimer's disease, major depressive disorder, and ataxia. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 had severe cognitive impairment and was dependent for activities of daily living. Music and doing things with other people was somewhat important to her and it was very important to do her favorite activities. Review of the activity preference assessment dated [DATE] revealed Resident #18 enjoys talking.Review of Resident #18's care plan dated 01/18/24 with a revision date of 02/06/24 revealed Resident #18 may continue to participate in group and/or 1:1 activity of her choice as tolerated. Review of Resident #18's medical record revealed no evidence the resident participated in 1:1 visits. Review of the activity department 1:1 list revealed Resident #18 was not on the list to have 1:1 visits.Observation and interview on 03/10/26 at 8:58 A.M. revealed Resident #18 was lying in bed with the bed against the wall, and the television (TV) was located on the opposite wall not within the resident's view. Resident #18 revealed activity staff do not visit her in her room.Interview on 03/11/26 at 3:20 P.M. with Activity Director (AD) #588 revealed activities are documented in the electronic chart and there was a one on one (1:1) visit binder. She stated she visits residents for 1:1 visits two to three times a week. AD #588 revealed Resident #18 used to come to BINGO, but the past several weeks she has been staying in bed due to pain. AD #588 revealed activities did not visit her on a 1:1 visit since she was staying in her room. There was no documentation that she was offered activities except for on 02/13/26 for a Valentines Day celebration. Interview on 03/11/26 at 4:35 P.M. with Activity Assistant (AA) #630 revealed she kept her own book of the residents she completes 1:1 visits for. AA #630 verified that Resident #18 was not on her list. Review of the undated facility policy titled, Activities Program, revealed that the facility will provide resident center care that meets the psychological, physical, and emotional needs and concerns of the residents.This deficiency represents non-compliance investigated under Complaint Number 2791091.

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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 medical record review, facility policy review, review of facility contracts, resident observation and interviews, and staff interview the facility failed to provide appropriate post dialysis evaluations for Residents #55 and #126. This affected two residents (Resident #55 and Resident #126) of two residents reviewed for dialysis care. There were 12 residents receiving dialysis care at the facility and the facility census was 125. Findings Include: 1. Review of the medical record for Resident #126 revealed admission to the facility on [DATE] with diagnoses including acute respiratory failure, lung disease, bipolar disorder (a mood disorder leading to periods of depression and mania), depression, anxiety, smoker, diabetes, heart failure, fibromyalgia (chronic generalized pain), and end stage renal disease with hemodialysis (a life saving treatment for individuals with severe kidney failure when blood is filtered outside of the body to remove waste and excess fluid). Further review of the medical record for Resident #126 revealed a brief interview for mental status completed on 03/04/26 with a score of 15/15, indicating that Resident #126 was cognitively intact. The minimum data set (MDS) comprehensive assessment was not yet completed with all items answered at time of the survey due to recent admission date of 03/04/26. Observation and interview on 03/17/26 at 12:11 A.M. with Resident #126 revealed resident resting in bed in no acute distress. Resident #126 confirmed that she was on dialysis and was receiving treatments downstairs at the dialysis center at the facility. Resident #126 confirmed that she is not always assessed after she returns from dialysis and further confirmed that the facility nurses do not check her vital signs when she has returned from dialysis. Review of the medical record for Resident #126 revealed she had refused dialysis treatments on 03/12/26 and alternate day of 03/13/26. The dialysis center was unable to provide dialysis on site on 03/14/26 and due to Resident #126 having a critical potassium level of 6.2 the dialysis center recommended Resident #126 be sent to the emergency room for emergency dialysis treatment. Resident #126 did receive dialysis treatment at the local emergency department and returned back to the facility the same day on 03/14/26. Further review of the medical record for Resident #126 revealed the treatment administration record (TAR) for 3/14/26 had no post dialysis vital signs or assessment completed. There was a post dialysis assessment completed by the facility on 03/05/26 and 03/07/26. There were no post dialysis assessments documented in the electronic medical record for 03/14/26. There were two communication hand-off sheets from the dialysis center dated 03/07/26 and 03/16/26 scanned into the medical record. Further review of the medical record revealed that the communication hand-off sheet completed on 03/16/26 had three sections: first section was for pre dialysis assessment and vitals signs and weights and area for added notes to be completed by the nursing home nurse, second section was to be completed by the dialysis nurse post treatment with updated vital signs, weights, and any recommendations, and the third section was to be completed by the nursing home nurse with follow up post dialysis vital signs, weight, and assessment findings. The communication hand-off sheet (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed on 03/16/26 for Resident #126 did not have anything documented on section three for post dialysis vital signs, weights, or assessment. Interview on 03/17/26 at 9:12 A.M. with Licensed Practical Nurse (LPN) #542 revealed that Resident #126 had been refusing dialysis and ended up having to for emergency dialysis treatment at the hospital on [DATE] but returned the same day. Interview on 03/17/26 at 10:45 A.M. with Assistant Director of Nursing (ADON) revealed she had brought all post dialysis communication forms and assessments for Resident #126 and had no other documents. ADON further reported that their facility only completes post dialysis assessment notes/UDA notes for residents who receive dialysis off site. Interview on 03/17/26 at 12:25 P.M. with LPN #504 revealed that Resident #126 had recently transferred to her unit yesterday 03/16/26. LPN #504 reported that Resident #126 did go to dialysis on site yesterday and returned in the evening. LPN #504 reported that all dialysis residents are to have a pre dialysis assessment of vital signs, weight, site access, bruit/thrill assessment. LPN #504 continued to report that post dialysis residents are to be assessed with vital signs and site access checked. LPN #504 produced the communication hand-off form for Resident #126 dated 03/16/26 and verified that the third section was not completed and that staff document on the TAR any vital signs and assessments completed and not on the communication form. 2. Review of the medical record for Resident #55 revealed they were admitted to the facility on [DATE] with diagnoses that included left femur fracture, end stage renal disease, dependence on renal dialysis, and diabetes mellitus type 2. Review of the five day Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #55 was able to understand and be understood, had adequate vision with glasses, was cognitively intact, did not reject care, required maximal assistance for most activities of daily living, and received dialysis. Review of the care plan dated 02/13/26 revealed Resident #55 was currently on dialysis therapy with the goal to be free from complications. Interventions included report abnormal findings to the medical provider and nephrologist (kidney doctor), coordinate resident care with the dialysis center, and evaluate the resident following dialysis treatment. Review of the current physician orders revealed the absence of an order for post-dialysis assessment for Resident #55. Review of the progress notes from 02/27/26 to 03/16/26 revealed the absence of post-dialysis assessment documentation. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) from 02/28/26 to 03/16/26 revealed the absence of post-dialysis assessment documentation. Review of the dialysis communication sheets from 03/02/26, 03/04/26, 03/06/26, 03/09/26, and 03/11/26 revealed the absence of a resident assessment post-dialysis, only the access site was assessed post treatment. An interview on 03/16/26 at 3:35 P.M. with the DON revealed the facility didn't assess residents' (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	post-dialysis, the facility used the last set of vital signs from the dialysis center located on the dialysis communication sheet. An interview on 03/16/26 at 4:07 P.M. with Licensed Practical Nurse (LPN) #656 revealed the facility didn't assess vital signs on residents' post-dialysis, the facility used the last set of vital signs from the dialysis center on the dialysis communication sheet and only assessed the access site post-dialysis. Review of the undated facility policy titled Hemodialysis Care and Monitoring, revealed the facility was to provide resident centered care, safety was a primary concern, the facility was to collaborate to develop and implement a dialysis care plan, and medication management required evaluation of vital signs before giving medications post-dialysis. The facility was also responsible for completing a post-dialysis evaluation by a nurse when the resident returned from the dialysis center which was to include access site monitoring, pulse in the access limb, blood pressure in the non-access arm, pulse in the non-access limb and respirations. The facility was also responsible for sharing communication with the dialysis center which was to include providing post-dialysis documentation to evaluate the resident's response to treatment and update the care plan accordingly. Review of the facility contract dated 05/05/2022 titled Dialysis Services Agreement revealed the facility was to comply with applicable practice and documentation standards, the dialysis provider was to provide training in monitoring residents post-dialysis, and the facility was to conduct post-dialysis assessments.

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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 record review, observations, interviews, and facility policy review the facility failed to maintain infection control by not disposing of used tracheostomy supplies and by not performing hand hygiene during incontinence care. These deficient practices affected two residents (Resident #12 and #44) out of nine residents reviewed for infection control. The facility census was 113.Findings Include: 1. Review of Resident #44's medical record revealed admission date 02/27/26 with diagnoses including but not limited to acute respiratory failure, epilepsy, kidney failure requiring hemodialysis, tracheostomy, and gastrostomy. Review of Resident #44's physician orders revealed an order dated 03/04/26 for tracheostomy care every shift. Review of Resident #44's care plan dated 03/06/26 revealed tracheostomy using Shiley (type of tracheostomy) size six extra-large with humidified air via trach collar. Review of Resident #44's Treatment Administration Record (TAR dated) 03/04/26 to 03/12/26 revealed the order for trach care was completed as ordered. Observation on 03/12/26 at 2:20 P.M. during trach care for Resident #44 revealed used trach collar with attached tubing laying on the table in the corner of Resident #44's room. There was a white washcloth laying on top of the used trach collar and no barrier underneath to where the used trach collar was laying on the tabletop. Interview on 03/12/26 at 2:40 P.M. with Registered Nurse #526 confirmed the used trach collar and attached tubing was laying on the table without a barrier underneath it between the tabletop and the trach collar. RN #526 stated the nurse must have removed the trach collar and tubing prior to Resident #44 going to dialysis. Review of the facility policy titled Infection Prevention Infection Control undated revealed standard precautions are universally applied in care and treatment of all residents regardless of their known or unknown infectious status. 2. On 03/09/26 at 8:49 A.M., an observation of incontinence care for Resident #12 revealed hand hygiene was not followed throughout the process. Certified Nurse Aide (CNA) #589 cleansed under the resident's panniculus (dense layer of excess subcutaneous fat and skin hanging from the lower abdomen) with gloves on. The area was reddened with chunks of old skin and powder being removed by the CNA. She proceeded to apply barrier cream to the resident and then to clean the resident's perineal area without performing hand hygiene or changing her gloves. She cleaned the resident, rolled her to her side, and with the assistance of CNA #587, she removed the resident from the bedpan. At that time she cleaned the bedpan, washed her hands and changed her gloves. She completed the remainder of the incontinence care including cleaning the resident's gluteal area without further hand hygiene until she had completed the care. On 03/09/26 at 9:10 A.M., an interview with CNA #589 confirmed she only completed hand hygiene one time during incontinence care for Resident #12. She stated she had been educated about hand hygiene but she could not remember when that was. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an undated facility policy titled Perineal Care-Male and Female, provided by the Director Nursing (DON), revealed the purpose of the policy was to provide personal care to promote a sense of well being and meet hygiene standards of care. The policy identified completing hand hygiene before applying gloves and beginning care. Hand hygiene would be performed after completing skin care and new gloves applied before completing bed care such as repositioning and cleaning the area. Once all care and clean-up was completed, the staff member should remove gloves and complete hand hygiene. Review of an undated facility policy titled Standard Precautions and Transmission Based Precautions, provided by the DON, revealed gloves were to be changed between clean and dirty tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms. Hand hygiene was to be performed each time gloves were removed and/or changed.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, interviews, and facility policy review the facility failed to ensure call lights within reach of residents. This deficient practice affected three residents (Residents #45, #112, and #116) out of three residents reviewed for call light use. The facility census was 113. Findings Include: 1. Review of Resident #112's medical record revealed admission date 11/22/24 with diagnoses including but not limited to dementia, depression and high blood pressure. Review of Resident #112's quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #112 had impaired cognition with a Brief Interview of Mental Status (BIMS) score of three out of possible 15 and required limited assistance from staff for completion of Activities of Daily Living (ADL) tasks. Review of Resident #112's care plan dated 12/04/24 revealed Resident #112's primary language was Spanish and Resident #112 had self-care deficit requiring staff assistance related to language barrier and impaired mobility. Observation on 03/09/26 at 9:55 A.M. revealed Resident #112's bed located against the wall and Resident #112 was laying in the bed sleeping. Resident #112's call light was observed attached to the privacy curtain across the room for Resident #112's bed. Interview on 03/09/26 at 10:14 A.M. with Registered Nurse (RN) #576 confirmed Resident #112's call light was attached to the privacy curtain across the room for where Resident #113 was sleeping in bed. 2. Review of Resident #116's medical record revealed admission date 03/05/24 with diagnoses including but not limited Alzheimer's disease, depression, anxiety, and high blood pressure. Review of Resident #116's annual MDS dated [DATE] revealed Resident #116 had impaired cognition with a BIMS score of five out of possible 15 and required staff assistance with ADL tasks. Review of Resident #116's care plan dated 03/06/24 impaired communication related to dementia, functional incontinence of bowel and bladder, and impaired mobility requiring staff assistance. Observation on 03/09/26 at 9:15 A.M. revealed Resident #116 sleeping in bed with no call light in reach. Further observation revealed both call lights were attached to the roommate's bed. Interview on 03/09/26 at 10:14 A.M. with RN #576 confirmed Resident #116's call light was attached to the roommate's bed and not in reach for Resident #116 to use if needed. Review of the facility's policy tilted Resident Rights undated revealed the right to have a method to communicate needs to staff, call light or bell access will be within reach of the resident as one method to communicate needs to staff. 3. On 03/09/26 at 7:30 A.M., an observation of the call light for Resident #45 revealed it was wound up over the call light actuator box near his recliner, and he could not reach it from the bed. His bed (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365292	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hanover Healthcare Center	435 Avis 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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	controller was on the floor at the foot of the bed, out of his reach. On 03/09/26 at 7:40 A.M., Director of Nursing confirmed Resident #45 could not reach his call light from his bed. He placed the call light within reach.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review the facility failed to ensure the environment was maintained in a sanitary and working manner. This affected two residents (#12 and #71) out of thirteen residents reviewed for environmental concerns. The facility census was 113. Findings include: 1. An observation on 03/09/26 at 10:44 A.M. revealed areas of grime and dirt on the side rails of Resident #71's bed. An observation on 03/11/26 at 7:32 A.M. revealed the same areas of grime and dirt on the side rails of Resident #71's bed. An observation on 03/11/26 at 11:53 A.M. revealed extensive dried food debris on the legs and post of the bedside table, the same areas of grime and dirt on the side rails, and the bed frame was visibly soiled with a large amount of splatter marks. An interview on 03/11/26 at 12:02 P.M. with Licensed Practical Nurse (LPN) #506 revealed any staff member could clean up messes on the floor, side rails, bedside table, and bed frame. LPN #506 verified the above findings at that time. An interview on 03/11/26 at 2:15 P.M. with the Director of Nursing (DON) revealed housekeeping is responsible for cleaning the residents room, bedside table, and side rail. Review of the facility policy titled Resident/Patient Room Cleaning dated 02/01/25 revealed the facility was committed to providing a clean and hygienic environment for residents in accordance with best practices, rooms would be cleaned regularly with a focus on high use surfaces such as bed rails, and visible soil was to be removed prior to disinfection. 2. On 03/09/26 at 8:48 A.M., an observation of Resident #12's bathroom revealed a sign on the toilet which read DO NOT USE. At the time of the observation, Resident #12 stated the toilet had been broken for several months. She had been told there was a crack or something in it and when it was used it would flood the entire bathroom. She said maintenance had been in several times to fix the issue, but they never seemed to get it corrected. This was confirmed by Registered Nurse (RN) #655 on 03/09/26 at 9:15 A.M. This deficiency represents non-compliance investigated under Complaint Number 2691714.