STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365321	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaks of West Kettering The	1150 West Dorothy Lane Kettering, OH 45409

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, staff interviews, facility policy review, and review of the guidelines from the National Pressure Ulcer Advisory Panel (NPUAP), the facility failed to thoroughly assess a resident's skin and failed to timely identify pressure ulcers (injuries to skin and underlying tissue caused by prolonged pressure, friction, or shear, usually over bony areas like the hips, heels, or tailbone) until they had reached an advanced stage. This resulted in Actual Harm for Resident #116 on 12/22/25, when the resident was admitted to the facility without pressure ulcers, was assessed to be at risk for development of pressure ulcers and developed an avoidable unstageable pressure ulcer (a full-thickness wound where damage depth is hidden by slough [a soft, moist, yellow or white devitalized tissue comprised of dead cells, fibrin, and bacteria that forms in the wound bed, acting as a significant barrier to healing by stalling the inflammatory phase] or eschar [a thick, dry, black or brown layer of dead tissue that forms over deep wounds] making an accurate stage assessment impossible and an unstageable pressure area signifies a deep stage III or IV ulcer requiring urgent medical attention) to the left heel. This affected one (Resident #116) of the three residents reviewed for pressure ulcers. The facility census was 107.Findings include:Review of the medical record for Resident #116 revealed an admission date of 11/12/25. Resident #116 was discharged home on [DATE]. Diagnoses included Alzheimer's disease, dementia, toxic liver disease, congestive heart failure (CHF), anxiety disorder, osteoarthritis, chronic kidney disease, and sepsis due to Escherichia coli (E-Coli), Review of the Baseline Care Plan for Resident #116 dated 11/12/25, revealed the resident no had no current skin issues and no history of skin integrity issues.Review of the physician order dated 11/12/25, revealed Resident #116 was ordered to receive weekly skin assessments and to be on a pressure-reduced mattress. Review of the Braden Scale for Predicting Pressure Sore Risk for Resident #116 dated 11/12/25, revealed the resident was at moderate risk for pressure related to skin breakdown. Review of the weekly skin assessment for Resident #116 dated 11/12/25, revealed no identified skin issues related to the left heel. Review of the physician order dated 11/24/25, revealed Resident #116 was ordered to have bilateral heels cleansed and skin prep applied every shift as a preventative measure. Review of the weekly skin assessments for Resident #116 dated 11/25/26, 12/02/26, and 12/06/25 revealed the resident's left heel was identified as being soft and blanchable and preventative measures dated 11/24/25 were to be in place. Review of the bathing documentation for Resident #116 dated 12/08/25,12/09/25, 12/10/25, 12/11/25, 12/12/25, 12/15/25, 12/17/25, 12/19/25, and 12/22/25, completed by Licensed Practical Nurse (LPN) / Wound Nurse #197 revealed the resident had blanchable redness to bilateral heels and no additional skin issues.Review of the weekly skin assessments for Resident #116 dated 12/12/25, revealed no identified skin issues on the left heel. Review of December 2025 Treatment Administration Record (TAR) for Resident #116 dated 12/19/25, 12/20/25, and 12/21/25, revealed the preventative measures (heels cleansed and skin prep applied every shift) were documented as being completed twice daily. Review of the bathing sheet for Resident #116 dated 12/22/25 authored by LPN#197, revealed the resident had no identified wounds or skin integrity issues on the left heel. Review of the nurse's progress note for Resident #116 dated 12/22/25 at 3:56 P.M. recorded as a late entry on (continued on next page)

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

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	12/23/25 and authored by LPN #197, revealed the resident had an open area on the left heel. The area had slight drainage, and the resident was at risk for skin integrity issues with preventative orders in place. The wound measured 4.5 centimeters (cm) in length by 3 cm in width by 0.1 cm in depth. Review of the weekly skin assessments for Resident #116 dated 12/23/25, authored by LPN #197, revealed an open area to the resident's left heel that measured 4.5 cm in length by 3 cm in width by 0.1 cm in depth.Review of the most recent Skin Breakdown Assessment for Resident #116 dated 12/23/25, revealed the resident had an open area to the left heel that measured 4.5 cm in length by 3 cm in width by 0.1 cm in depth. Review of the most recent Braden Scale for Predicting Pressure Sore Risk for Resident #116 dated 12/23/25, revealed the resident was at high risk for skin breakdown. Review of a facility document titled Wound Evaluation Observation for Resident #116 dated 12/24/25, signed as completed on 01/05/26 by 3:19 P.M. by LPN #197, revealed the resident was identified with a wound to the left heel acquired in-house on 12/22/25. The wound was unstageable, with granulation tissue present, and 90 percent necrotic tissue (dead or devitalized cells that cannot be salvaged, appearing as discolored [black, brown, yellow]), exudate (drainage) was small serosanguinous (mix of pale yellow [serous] fluid and light red [sanguineous/blood] fluid, commonly seen in the first 24-72 hours of healing) with necrotic tissue at 90 percent and granulation tissue at 10 percent (new, vascularized connective tissue that forms on the surface of a healing wound during the proliferative phase, appearing as red, moist). The measurements were 4 cm in length by 4.3 cm in width by 0.2 cm in depth. The treatment consisted of Vashe gauze applied for antimicrobial protection and autolytic debridement and would be evaluated weeklyReview of the physician order dated 12/24/25, revealed Resident #116 was ordered to have heel boots applied as tolerated every shift. Review of Wound Nurse Practitioner (WNP) #550's note for Resident #116 dated 12/24/25 at 3:38 P.M. revealed the resident was assessed with a new in-house acquired unstageable pressure wound on the left heel. The wound measured 4 cm in length by 4.3 cm in width by 0.2 cm in depth with small amount of serosanguinous exudate, 90 percent necrotic tissue and 10 percent granulation. Treatment consisted of Vashe soaked gauze pads for antimicrobial protection and autolytic debridement with a bordered gauze applied daily and as needed. Review of the WNP #550 note for Resident #116 dated 12/31/25, revealed the resident complained of pain in left heel. The resident's wound was still an unstageable pressure wound on the left heel that measured 2 cm in length by 4 cm in width by 0.2 cm in depth with moderate amount of serosanguinous exudate, 30 percent of slough (a soft, moist, yellow or white devitalized tissue comprised of dead cells, fibrin, and bacteria that forms in the wound bed, acting as a significant barrier to healing by stalling the inflammatory phase), 40 percent necrotic tissue and 30 percent granulation. Treatment consisted of Vashe soaked gauze pads for antimicrobial protection and autolytic debridement with a bordered gauze applied daily and as needed. Review of the Interdisciplinary Team (IDT) note for Resident #116 dated 12/28/25 at 3:17 P.M. authored by the Director of Nursing (DON), revealed the team reviewed the pressure ulcer identified on 12/22/26. The floor nurse notified the wound nurse of a new open area to the resident's left heel. The resident had an area to the left heel with slight drainage. New treatment and monitoring orders were put in place. Resident #116's daughter was notified and the facility would continue to monitor signs and symptoms of changes or infection.Review of the physician order dated 12/28/25, revealed Resident #116 was ordered to have the left heel monitored for signs and symptoms of change or infection every shift. Review of the comprehensive plan of care for Resident #116 revised on 12/30/25, revealed the resident had impaired skin integrity related to a pressure ulcer on the left heel and an arterial ulcer to left medial toe secondar to skin breakdown, immobility, and medical comorbidities. Interventions included: supplemental protein, amino acids, vitamins, and minerals as ordered, provide/encourage/assist with application of heel protectors/moon boots to be worn at all times, treat pain as ordered to ensure comfort, consult with a wound nurse, encourage the resident to float heels, encourage/assist resident to turn and reposition every two hours, utilize positioning devices as needed, follow facility protocols and policies related to skin breakdown, monitor/document/report to (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	physician any changes in skin status, pressure relieving mattress/alternating pressure air mattress.Review of the physician visit note for Resident #116 recorded as a late entry on 12/30/25 for a visit dated 12/28/25 and authored by Medical Director (MD) #500, revealed Resident #116 was seen for osteoarthritis. Resident #116 had no new complaints, and the facility reported no new concerns at this time. There was no documentation by MD #500 regarding the new unstageable pressure wound on the resident's left heel identified on 12/22/26.Review of the physician order dated 01/02/26, revealed Resident #116 was ordered to have the left heel monitored for signs and symptoms of infection and notify the physician if any signs of infection. Review of the physician order dated 01/21/26, revealed Resident #116 was ordered to have the left heel wound cleansed, patted dry, a nickel thick layer of Santyl applied, followed by calcium alginate, and a boarder gauze every night shift and as needed.Review of the Minimum Data Set (MDS) assessment, dated 01/30/26, for Resident #116 revealed she had severely impaired cognition. Resident #116 was dependent on staff for all activities of daily living. During an interview on 02/24/26 at 1:19 P.M., LPN #197 stated she was the nurse who identified Resident #116's left heel wound on 12/22/25. LPN #197 stated she discovered the wound during a facility wide skin sweep related to an increase in self-reported incidents (SRI) and increase in wounds. LPN #197 stated the skin sweeps were documented on the Bath and Shower Documentation Sheets. LPN #197 stated she started daily skin sweeps in the Memory Care Unit (MCU). LPN #197 stated Resident #116 did not have any Wound Nurse Practitioner (NP) visits during the weeks of 12/10/25 and 12/17/25 because a previous skin issue in a different location had been resolved. LPN #197 stated she completed a skin sweep on 12/22/25 and identified an unstageable pressure wound on the residents left heel. During an interview on 02/25/26 at 10:37 A.M., WNP #550 verified Resident #116 developed an in-house unstageable pressure ulcer to he left heel identified by the staff on 12/22/25. Review of the facility policy titled, Wound Management and Documentation dated 12/2024, revealed the facility would complete accurate documentation of treatments and focused wound assessments, including response to treatment, change in condition, and changes in treatment. Focused wound assessments were to be documented weekly, and as needed if the resident or wound condition deteriorates.Review of the National Pressure Injury Advisory Panel (NPIAP) guidelines, dated 2014, pages 70-71, at (https://npiap.com/general/custom.asp?page=2014Guidelines), revealed facilities should educate health professionals on how to undertake a comprehensive skin assessment that includes the techniques for identifying blanching response, localized heat, edema, and induration. Further review of the guidelines revealed ongoing assessment of the skin was necessary to detect early signs of pressure damage. Visual assessment for erythema (redness of the skin) was the first component of every skin inspection. Skin redness and tissue edema resulting from capillary occlusion was a response to pressure, especially over bony prominences. Staff should conduct a head-to-toe assessment with particular focus on skin overlying bony prominences including the sacrum, ischial tuberosities, greater trochanters and heels and each time the patient was repositioned was an opportunity to conduct a brief skin assessment. Unstageable pressure ulcer is defined as a depth unknown full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/Stage, cannot be determined.

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 record review, review of emergency room (ER) records, staff interview, review of the facility's investigation and policy review, the facility failed to ensure a resident was safely turned in bed during incontinence care resulting in the resident falling out of bed. This resulted in Actual Harm when Certified Nursing Assistant (CNA) #355 was providing incontinence care to Resident #116 and the resident rolled out of the bed onto the floor. Resident #116 was sent to hospital and was diagnosed with a head injury which required staples. This affected one (Resident #116) of the three residents reviewed falls. The facility census was 107.Findings included: Review of the medical record review for Resident #116 revealed an admission date of 11/12/25 and discharged home on [DATE]. Diagnoses included toxic liver disease, congestive heart failure, constipation, anemia, anxiety disorder, Alzheimer's disease, osteoarthritis, chronic kidney disease, sepsis due to Escherichia coli, and dementia.Review of comprehensive plan of care for Resident #116 dated 11/16/25, revealed the resident had an activity of daily living (ADL) self-care performance deficit related to confusion/dementia and the level of assistance from staff varied throughout the day. The resident had behaviors related to being resistive to care resulting in injury. Interventions included: monitor and anticipate the resident's care needs, scoop mattress, and assess the resident for fall risks. There was no plan of care implemented for the resident being at risk for falls and no interventions implemented until after the fall occurred on 11/24/25. Review of the Interdisciplinary Team (IDT) note dated 11/21/25 at 5:00 A.M. and recorded as a late entry on 12/01/25 at 4:44 P.M. and authored by the Director of Nursing (DON), revealed CNA #355 provided care for Resident #116 and once completed, CNA #355 turned to reach for the bed remote to lower the bed when Resident #116 shifted in the bed resulting in the resident rolling off the bed. Registered Nurse (RN) #134 was alerted and upon the nurse's entry into the resident's room, Resident #116 was lying on the floor with a laceration on the left forehead. The new intervention was a two-person assistance with bed mobility and transfers to reduce the risk of further falls and injury.Review of witness statement by CNA #355 dated 11/21/25 (three days prior to the incident), revealed CNA #355 provided incontinence care to Resident #116 and when finished, CNA #355 turned to get the remote for the bed so the bed could be lowered and Resident #116 rolled out of bed. CNA #355 got RN #134 to assess the resident.Review of the nurse's progress note for Resident #116 dated 11/24/25 at 5:42 A.M. and authored by RN #134, revealed the nurse was called into the resident's room by CNA #355 related to injuries the resident sustained after falling out of the bed. Resident #116 had a laceration to the top of the head, with a significant amount of blood. Direct pressure was applied to the site until emergency medical services (EMS) arrived. CNA # 355 reported Resident #116 decided to roll towards the floor from the bed during personal care. CNA #355 indicated the bed was up high and the bed rails were down. The new interventions included adding bedrails to the bed and two-person assistance required for care. Review of the ER records for Resident #116 dated 11/24/25 at 6:34 A.M., revealed the resident was admitted to the ER for a closed head injury, scalp laceration, and cervical strain. The head wound was 3.2 centimeters (cm) in length and four staples were placed. Resident #116 was discharged from the hospital on [DATE] at 10:44 A.M.Review of the Incident Report dated 11/24/25 at 5:00 A.M., and authored by RN #134, revealed the nurse was called to Resident #116's room due to a fall with injuries to the resident's head. Resident #116 had a laceration to her head with a significant amount of blood and vital signs were taken. Direct pressure was applied to the site until EMS arrived. The new intervention was to add side rails and a two-person assist for all personal care. The physician and family members were notified of the fall. Review of the physician progress notes for Resident #116 dated 11/30/25 at 3:00 A.M. and recorded as a late on 12/01/25 at 1:00 P.M., revealed Resident #116 was assessed by Medical Doctor (MD) #500 and the primary reason for visit was listed as (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	osteoarthritis. Resident #116 was listed as having no new complaints and the facility had no concerns. There was no documentation related to the witnessed fall on 11/24/25. Review of a Fall Risk Assessment for Resident #116 dated 12/02/25, revealed the resident was at high risk for fallsReview of the Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #116 had severely impaired cognition. Resident #116 was dependent on staff for all activities of daily living. During an interview on 02/24/26 at 4:30 P.M., the Administrator stated CNA #355's write-up on 11/25/25 was directly related to the incident involving Resident #116's fall on 11/24/25. The Administrator verified CNA #355 was terminated related to Resident #116 rolling out of bed during his care on 11/24/25. The Administrator verified CNA #355 diverted his attention away from Resident #116 and the resident rolled out of bed causing the injuries to the resident's head. During an interview on 02/24/25 at 4:45 P.M., RN #134 stated she was responsible for caring for Resident #116 on 11/24/25 around 5:42 A.M. when the resident rolled out of bed during care by CNA #355 and sustained a head injury. RN #134 stated CNA #355 called her into the resident's room after the resident had a fall with injury. RN #134 stated CNA #355 reported that he provided personal care to Resident #116 and turned to grab something and Resident #116 rolled off the bed. RN#134 stated there was a lot of blood, and she had to hold a washcloth to Resident #116's head to try and control the bleeding. RN #134 stated she incorrectly documented that there were no bedrails in place when the resident fell but later realized the bed rails were down because CNA #355 had the bed in the highest position during care. RN #134 stated she recommended the intervention for Resident #116 to be a two-person assist with care and transfers.Review of the employee file for CNA #355 on 02/25/26 at 1:00 P.M., revealed he was hired on 05/07/25. CNA#355's employee file had a write up for 11/25/25 related to poor work performance. CNA #355 was terminated on 12/11/25 related to poor work performance. During an interview on 02/25/26 at 3:26 P.M., the DON stated the facility does not review falls as an IDT. The DON stated the nurse on duty would complete the risk assessment investigation and should put an immediate intervention in place. The DON stated she would review the interventions after the nurse put something in place. The DON stated she is the only one from the IDT that reviewed falls after an incident. The DON stated she has been in the DON role for four weeks; however, prior to the role of DON she was the Assisted Director of Nursing (ADON) at the time of the incident on 11/24/25. The DON stated the IDT meets once monthly and would review falls. The DON stated the facility has not completed any IDT meetings since she took over the DON role. Review of facility policy titled, Fall Prevention Program, dated 06/17/25, revealed each resident would be assessed for fall risk and would receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Upon admission, the nurse would complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk, and provide interventions as directed by the IDT review, including but not limited to assisted devices, medication review, low bed, alternate all system access, scheduled ambulation or toileting assistance, family/resident education, and therapy services referral.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, staff interview, and review of the facility policy, the facility failed to assess residents for the use of bedrails prior to application of bed rails to the residents' beds. This affected 19 (Residents #3, #5, #6, #7, #9, #10, #13, #58, #61, #62, #65, #66, #67, #68, #69, #71, #72, #73, #74) of 19 residents reviewed for bed rails. The facility census was 107 residents. Findings include: Observation on 02/20/26 at 5:40 P.M. with the Director of Nursing (DON) revealed the following residents had bedrails on their beds: #3, #5, #6, #7, #9, #10, #13, #58, #61, #62, #65, #66, #67, #68, #69, #71, #72, #73, #74. Interview on 02/20/26 at 5:44 P.M. with the Director of Nursing (DON) confirmed the following residents had bedrails on their beds: #3, #5, #6, #7, #9, #10, #13, #58, #61, #62, #65, #66, #67, #68, #69, #71, #72, #73, #74, The DON further confirmed the facility failed to assess these residents for the use of bedrails prior to the application of bed rails to the bed. Review of the facility policy titled, Side Rails (Bed Rails)-Use and Monitoring dated 02/05/26 revealed the facility staff will assess the resident for the appropriateness of bedrails prior to use. The facility will attempt and document attempts at use of less restrictive measures prior to use of bedrails.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on medical record review, staff interview, hospice interview, review hospice contracts, and review of the facility policy, the facility failed to ensure a communication process with the hospice company regarding documentation and coordination of care. This affected three (Residents #14, #70, #73) of six residents on hospice. The facility census was 71 residents.Findings include: 1.Review of the medical record for Resident #14 revealed an admission date of 10/01/24 with diagnoses including hypertension, chronic kidney disease, dementia, and anorexia.Review of the physician's orders for Resident #14 revealed an order dated 06/19/25 indicating the resident was admitted to Hospice Company B with a terminal diagnosis of senile degeneration of brain.Review of the Minimum Data Set (MDS) assessment for Resident #14 dated 12/27/25 revealed the resident had impaired cognition, required staff assistance with activities of daily living (ADLs), and was not marked as receiving hospice services. Review of the progress notes for Resident #14 dated January 2026 and February 2026 revealed the notes did not include documentation regarding hospice services. Review of the revocation of hospice services form for Resident #14 dated 01/08/26 revealed the resident revoked the services of Hospice Company B. Review of the physician's orders for Resident #14 revealed an order dated 01/09/26 indicating the resident was admitted to Hospice Company A with a diagnosis of senile degeneration of brain. Review of the hospice election form for Resident #14 dated 01/09/26 revealed the resident signed with Hospice Company A. Review of the hospice communication book for Hospice Company A for Resident #14 revealed the only information included was a signature per Registered Nurse (RN) #575 dated 02/18/26 for a visit. There was no other information regarding Resident #14 in the hospice communication book for Hospice Company A. Interview on 02/25/26 at 3:25 P.M with the Director of Nursing (DON) confirmed the facility failed to document Resident #14's hospice services in the facility progress notes and the hospice documentation did not reflect the hospice visits for the resident 2. Review of the medical record for Resident #70 revealed an admission date of 02/15/24 with diagnoses including congestive heart failure (CHF), dysphagia, adult failure to thrive, hypertension, and peripheral vascular disease.Review of the physician's orders for Resident #70 revealed an order dated 06/19/24 indicating the resident was admitted to Hospice Company B with a terminal diagnosis of cerebral atherosclerosis. Review of the physician's orders for Resident #70 revealed an order dated 01/08/26 indicating the resident was admitted to Hospice Company A with a diagnoses of chronic obstructive pulmonary disease (COPD). Review of the MDS assessment for Resident #70 dated 01/19/26 revealed the resident was severely cognitively impaired, required assistance with ADLs, and received hospice services. Review of the progress notes for Resident #70 dated January 2026 and February 2026 revealed the notes did not include documentation regarding hospice services. Review of the revocation of hospice benefit form for Resident #70 dated 01/07/26 revealed Hospice Company B services were revoked. Review of the hospice election form for Resident #70 dated 01/08/26 revealed the resident signed with Hospice Company A. Review of the physician order summary for Resident #70 revealed an order dated 01/12/26 to admit to Hospice Company A with a diagnosis of COPD. Review of the hospice communication book for Hospice Company A for Resident #70 revealed the only information included was a signature per RN #575 dated 02/18/26 for a visit. There was no other information regarding Resident #70 in the hospice communication book for Hospice Company A. Interview on 02/25/26 at 3:26 P.M with the DON confirmed the facility failed to document Resident #70's hospice services in the facility progress notes and the hospice documentation did not reflect the hospice visits for the resident. 3. Review of the medical record for Resident #73 revealed an admission date of 05/30/25 with diagnoses including acute kidney failure, hypertension, CHF, generalized anxiety disorder, and vascular dementia. Review of the physician's orders for Resident #73 revealed and order dated 10/08/25 for the resident to admit to Hospice Company B. Review of the revocation form of hospice services for Resident #73 dated (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	01/04/26 revealed the resident revoked hospice services with Hospice Company B. Review of the hospice election form for Resident #73 dated 01/05/26 revealed the resident admitted to Hospice Company A. Review of the physician's orders for Resident #73 revealed an order dated 01/05/26 for the resident to admit to Hospice Company A with a diagnosis of terminal dementia. Review of the MDS assessment for Resident #73 dated 01/16/25 revealed the resident had severely impaired cognition, was dependent on staff with ADLs, and was marked as receiving hospice services. Review of the progress notes for Resident # 73 dated January 2026 revealed the notes did not include documentation regarding hospice services. Review of the hospice communication book for Hospice Company A for Resident #73 revealed the only information included was a signature per RN #575 dated 02/18/26 for a visit. There was no other information regarding Resident #73 in the hospice communication book for Hospice Company A. Interview on 02/25/26 at 3:27 P.M. with the DON confirmed the facility failed to document Resident #70's hospice services in the facility progress notes and the hospice documentation did not reflect the hospice visits for the resident. Interview on 02/25/26 at 3:36 P.M. with Business Development Director (BDD) # 425 for Hospice Company A confirmed the hospice contract between Hospice Company A and the facility was signed on 01/05/26. BDD #425 confirmed Company Hospice A had an office behind the nurse's station on the memory care unit. BDD #425 confirmed the hospice company was behind on their documentation and failed to document visits for Residents #14, #70, and #73. Review of the facility contract with Hospice Company A dated 01/05/26 revealed the hospice company would provide hospice services 24 hours a day seven days a week. The hospice company should keep accurate records of hospice services provided to each hospice patient and the records should be located at the facility and would be deemed the facility's property. Review of the facility policy titled Hospice Services Facility Agreement undated revealed the facility would arrange for hospice services and would ensure a communication process for coordination of care between the hospice company and the facility to include documentation and record keeping requirements.