STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365329	A. Building B. Wing	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marion Nursing & Rehab	175 Community Drive Marion, OH 43302

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of the Minimum Data Set (MDS) Resident Assessment Instrument, review of facility policy, and interview, the facility failed to ensure all resident assessments were accurate and coded correctly in the MDS database. This affected six residents (#3, #21, #28, #44, #53, and #62) out of 24 residents reviewed for MDS assessments. The census was 67.Findings include:1.Record review for Resident #3 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #3 included congestive heart failure, chronic obstructive pulmonary disease, obesity, depression, diabetes type two, and anxiety. Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed the resident had intact cognition, required two staff assistance with Activities of Daily Living (ADLs) and was receiving supplemental oxygen therapy, but was not coded for any type of mechanical ventilation. Review of the MDS quarterly assessment dated [DATE] revealed the resident was coded for an invasive mechanical ventilator. Review of Resident #3's physician orders dated 08/29/25 revealed the resident was ordered to receive mechanical ventilator via Average Volume Assured Pressure Support (AVAP) for morbid obesity and alveolar hypoventilation primary central sleep apnea. Review of Resident #3's care plans dated 10/15/25 revealed a focus for ventilator dependence related to nocturnal vent (AVAP) at bedtime and as needed. Interventions included to allow resident to express feelings about ventilator, educate resident on need for the treatments, elevate head of bed, keep call light within reach, and maintain AVAP ventilator settings as ordered. Observation on 02/09/26 at 8:33 P.M. revealed the resident was lying in bed with a nasal cannula in place. Resident #3 was observed with his eyes closed and respirations unlabored. At the time of the observation Resident #3 did not appear to be in any distress and was not using the mechanical ventilator. Interview on 02/10/26 at 11:00 A.M. with Resident #3 revealed the resident stated he did not like to use the AVAP and refused to use the mask. Resident #3 verified he had not had any endotracheal tubes or a tracheostomy tubes to assist his breathing. Resident #3 verified he was to use a face mask at night during sleep which was connected to the ventilator. Interview on 02/10/26 at 3:51 P.M. with the Administrator revealed the facility MDS nurse and the Administrator were instructed by the facility's corporate MDS nurse to have the Resident #3's MDS code changed to invasive mechanical ventilator due the Resident Assessment Tool stating the APAV ventilator could be used as an 'invasive' ventilating machine. At the time of the interview the (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administrator verified there were no residents in the facility who had endotracheal or tracheostomy tubes connected to the ventilators provided respiratory support. Interview on 02/17/26 at 8:00 A.M. with MDS Nurse/Licensed Practical Nurse (LPN) #241 verified there were no residents in the facility using endotracheal or tracheostomy tubes for mechanical ventilation. LPN #241 verified she was instructed by the corporate MDS nurse to code Resident #3 as using an invasive mechanical ventilator in the MDS assessment dated [DATE]. Interview on 02/18/26 at 10:30 A.M. with Respiratory Therapist (RT) #400 and Respiratory Therapy Manager (RTM) #401 via the telephone verified all residents in the facility ordered to use the AVAP machines were using the facial masks at night and as needed per the physician's order. Per RTM #401 and RT #400 the residents were not being provided an invasive ventilator by the AVAP machines. RT #400 and RTM #401 verified the AVAP machines were being used by the residents as a non-invasive machines. 2. Record review for Resident #53 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #53 included chronic obstructive pulmonary disease, sleep apnea, myocardial infarction, heart disease, and hypertension. Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed the resident was using invasive mechanical ventilation. Review of Resident #53's care plans dated 09/19/25 revealed a focus for the resident being ventilator (AVAP) dependent related to chronic obstructive pulmonary disease. Interventions included to maintain APAV machine setting as ordered. Review of Resident #53's physician orders dated 09/19/25 the resident was ordered to receive mechanical ventilator via Average Volume Assured Pressure Support (AVAP) for chronic obstructive pulmonary disease and primary central sleep apnea at night and as needed. Interview on 02/10/26 at 3:30 P.M. with Resident #53 revealed the resident stated he did not use the mechanical ventilator all the time and used it sometimes at night for short periods of time. Resident #53 verified he only used the ventilator with the facial mask and had not had any endotracheal or tracheostomy tubes. Resident #53 stated he had refused to use the APAV machine many times and was educated by staff on why he should wear the mask at night while he sleeps. Interview on 02/18/26 at 10:30 A.M. with RT #400 verified Resident #53 had refused to use the APAV ventilator at times while he sleeps. RT #400 verified when Resident #53 was using the APAV ventilator, it was in a non-invasive way. Interview on 02/18/26 at 10:35 A.M. with MDS LPN #241 verified Resident #53 was coded in the 09/2025 MDS assessment as using an invasive mechanical ventilator. LPN #241 verified Resident #53 used the facial mask when he agreed to use the APAV ventilator. 3. Review of the medical record for Resident #28 revealed an admission date of 07/18/24 with diagnoses of dementia, dependence on respirator status, [NAME] cardia, central sleep apnea and chronic respiratory failure. Review of quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #28 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/18/26 at 10:35 A.M. with MDS Nurse/Licensed Practical Nurse (LPN) #241 revealed Resident #62 was compliant with using the facial mask with the APAV ventilator at night while she slept. LPN #241 verified during the day the resident was on room air. LPN #241 verified Resident #62 was coded in the MDS assessments as using an invasive mechanical ventilator. Review of the undated facility policy titled, 'Policy and Procedure: AVAPS (Average Volume Assured Pressure Support) Therapy revealed the procedure was for the safe use of monitoring residents using the AVAPs as a non-invasive ventilation therapy in the facility. Review of the Minimum Data Set 3.0 Resident Assessment Instrument dated 10/2025 revealed the facility may code any type of electrically or pneumatically powered closed-system mechanical ventilator support device that ensures adequate ventilation in the resident who is or who may become unable to support their own respiration. During invasive mechanical ventilation the resident's breathing is controlled by the ventilator. Residents receiving closed-system ventilation include those residents receiving ventilation via an endotracheal tube or tracheostomy. Do not code this item when the ventilator or respirator is used as a substitute for BiPAP or CPAP. 5. Review of the record for Resident #21 revealed the resident was admitted on [DATE] and had diagnoses including encephalopathy, chronic obstructive pulmonary disorder (COPD), and chronic embolism and thrombosis of deep veins of lower extremity. Review of the Minimum Data Set (MDS) assessment for Resident #21 completed 01/22/26 documented the resident was not using an anticoagulant medication. Review of the Medication Administration Record (MAR) for Resident #21 for January 2026 documented daily administration of Rivaroxaban 20 milligrams (mg) (an anticoagulant medication). Interview with Director of Nursing (DON) #272 on 02/17/26 at 9:30 A.M. confirmed the residents MDS was incorrectly coded. 6. Review of the record for Resident #44 revealed the resident was admitted on [DATE] and had diagnoses including metabolic encephalopathy, hypertensive heart disease, and atherosclerotic heart disease. Review of the Minimum Data Set (MDS) assessment for Resident #44 completed 01/22/26 documented the resident was not using a diuretic medication. Review of the Medication Administration Record (MAR) for Resident #44 for January 2026 documented daily administration of Hydrochlorothiazide 25 milligrams (mg) (a diuretic medication). Interview with Director of Nursing (DON) #272 on 02/17/26 at 9:31 A.M. confirmed the residents MDS was incorrectly coded.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record review, interview, and review of facility policies, the facility failed to ensure a residents advanced directives status were addressed timely and accurate in the medical record. This affected one (Resident #59) out of 27 residents reviewed for advanced directives. The facility census was 67.Findings include: Review of the medical record for Resident #59 revealed an admission date of 08/22/25 with diagnoses including chronic obstructive pulmonary disease, emphysema, encephalopathy, malignant neoplasm, fibromyalgia and dementia.Review of Resident #59's physician orders dated 08/22/25 through 02/10/26 showed a Full Code status.Review of Resident #59's quarterly Minimum Data Set (MDS) 3.0 assessment completed on 11/12/25 showed the resident was cognitively intact.Review of Resident #59's care conference notes dated 12/04/25 showed the resident requested to change her code status from Full Code to Do Not Resuscitate Comfort Care (DNRCC).Review of Resident #59's signed DNRCC form dated 02/03/26 showed the resident elected DNRCC Arrest (A) which directs providers to treat the patient as usual until cardiac or respiratory arrest at which point all interventions stop.Review of Resident #59's physician orders dated 02/10/26 showed a code status of DNRCC-A.Review of Resident #59's care plan dated 02/10/26 showed a code status of DNRCC-A with interventions to provide comfort measures and verify resident choice quarterly.Interview on 02/17/26 at 11:55 A.M. with the Director of Nursing confirmed Resident #59 requested to be DNRCC during the care conference on 12/04/25 however the request was not implemented until 02/03/26 when a new code status form was completed.Interview on 02/17/26 at 12:49 P.M. with Social Services #119 confirmed the resident request for a code status change was not followed up on 12/04/25 and was only addressed on 02/03/26.Review of code status policy dated December 2016 revealed the plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive. In addition, inquiries concerning advanced directives should be referred to the administrator, director of nursing and/or the social services director.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure a resident's splint noncompliance was recorded in their care plan. This affected one (Resident #57) out of 17 residents records reviewed for comprehensive care plans. The facility census was 67. Findings include:Review of the medical record for Resident #57 revealed an admission date of 02/08/19 with diagnoses of cerebral infarction, muscle weakness, cognitive communication deficit, reduced mobility, contracture of the right hand, hemiparesis and hemiplegia following cerebral infarction.Review of the care plan dated 11/14/25 revealed the resident had a need for a splint or brace program and was dependent on staff for application and removal. Interventions included assessing for pain, assessing for progress and need, explaining the procedure before performing it and applying a soft splint to the right hand to be worn daily as tolerated. The care plan noted no documentation regarding the residents refusal of the splint or brace.Review of physician orders dated 01/01/26 revealed an order for a right hand splint as tolerated and to assess skin with each application and removal.Review of the occupational therapy evaluation and plan of treatment dated 01/09/26 revealed the resident exhibited impaired range of motion in the right extremity including wrist, hand and fingers and included interventions for splint management.Review of splint application documentation dated 01/19/26 through 02/16/26 revealed the resident refused the splint a total of 20 times.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was severely cognitively impaired, had an upper extremity impairment on one side, required substantial to maximal assistance with upper body dressing and receives splint or brace assistance.Observations on 02/11/26 at 8:35 A.M., 3:21 P.M. and 4:20 P.M. revealed the resident lying in bed with no splint placed on the right hand.Observation on 02/17/26 at 9:20 A.M. revealed the resident lying in bed with no splint placed on the right hand.Observation and interview on 02/17/26 at 10:33 A.M. with Resident #57 revealed the resident reported noncompliance with wearing the splint because it was uncomfortable. The resident stated he occasionally allowed staff to place the splint, but not often, and reported wearing the device a couple of days ago.Interview on 02/17/26 at 10:37 A.M. with Licensed Practical Nurse (LPN) #268 confirmed the resident was noncompliant with wearing the right-hand splint and LPN #268 was unaware if this was currently care planned.Interview on 02/17/26 at 11:55 A.M. with the Director of Nursing confirmed the resident's noncompliance with wearing the splinting device should be documented in the care plan.Interview on 02/17/26 at 12:43 P.M. with the Director of Nursing confirmed that from 01/19/26 through 02/16/26 the resident refused the splint a total of 20 times.Review of the splinting and bracing policy dated October 2023 revealed the care plan will be updated as necessary based on changes in the resident.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of hospital notes, review of facility timeline, interview, and review of facility policies and procedures, the facility failed to follow interventions to prevent a fall. This affected one resident (#3) out of three residents reviewed for falls. The facility also failed to ensure the safety and security of Resident #75 who was admitted to the memory care unit and was an elopement risk. This affected one resident (#75) of three reviewed for elopement. The facility census was 67.Findings include: 1. Record review for Resident #3 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #3 included congestive heart failure, chronic obstructive pulmonary disease, obesity, depression, diabetes type two, and anxiety. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition, required two person assistance with Activities of Daily Living (ADLs) and was a fall risk. Review of Resident #3's care plan dated 09/25/21 revealed a focus identifying a risk of falls. Interventions included bedside table to be within reach at all times, maintain call light within reach, resident prefers the call light to be wrapped around the transfer handle on bed, initiated on 11/26/25 and revised on 02/12/26. Review of the facility's incident log dating from October 2025 to February 2026 revealed Resident #3 had an unwitnessed fall in his room on 11/26/25. Review of the fall investigation dated 11/26/25 revealed the Director of Nursing (DON) documented Resident #3 was observed lying on the floor on his left side. The resident's bed was noted to be in a raised position. Resident #3 stated he was reaching for his call light and fell out of bed. Emergency services were called and the resident was assessed by the emergency squad and refused to go to the hospital. Resident #3 was placed back in bed and was provided as-needed pain medication. Per the investigation the care plan was updated to keep call light within reach by wrapping it around the transfer handle. Observation on 02/10/26 at 11:00 A.M. revealed Resident #3 was resting in bed, the bed was raised to an elevated height and the resident's call light was clipped to the bed sheet at the head of the bed. Interview on 02/10/26 at 11:00 A.M. with Resident #3 revealed the resident reported he had received a new bed at the facility and it did not have the two transfer bars attached for the first few days he was using the bed. Resident #3 stated he had raised the bed up to high level and he was attempting to get his call light that was out of his reach on the table, which was also out of his reach, and he rolled out of the bed onto the floor. Resident #3 stated he had been educated to not raise the bed to the highest level, but he preferred to have the bed raised up despite the fall risk. Resident #3 stated he would not have rolled out of the bed and fallen had the call light been within his reach or if the grab bars had been in place for him to use. Resident #3 stated he believed the fall was both his fault for raising the bed so high and the fault of the facility staff for not placing his call light within his reach and not applying the grab bars on his new bed. Interview on 02/12/26 at 11:00 A.M. with Licensed Practical Nurse (LPN) #285 revealed Resident #3 was non-compliant with not raising his bed to a high level by himself. LPN #285 stated at the time of (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the fall on 11/26/25 the resident had been provided care by the staff, and the bed was at a low position when the LPN last visited the room, but the resident raised the bed after the staff left his room. LPN #285 stated she could not recall if the call light was placed within the reach of the resident when she left the room. LPN #285 stated when the resident was found he was alert and stated his call light was out of reach and he was attempting to get it when he rolled out of bed. LPN #285 stated the resident has not fallen since the 11/26/25 incident. Interview on 02/17/26 at 11:50 A.M. with the DON revealed at the time of the fall Resident #3 had received a new bariatric bed and there was no grab bars attached to the bed. DON verified the new bed had not been assessed and there had not been a bed rail assessment completed for Resident #3 in the new bed until 12/08/25. DON stated she had discussed with the resident having the call light clipped to his person, but he preferred to have the call light wrapped around the transfer bar above his bed so he could reach up and push it. DON verified per the investigation the call light was not within reach of the resident when he rolled out of bed on 11/26/25. 2. Review of the medical record for Resident #75 revealed an admission date of 02/05/26. Diagnoses included Alzheimer's disease, diabetes, hypertension, and dementia. Review of the admission elopement assessment dated [DATE] revealed Resident #75 scored a three and was found to be a low risk for elopement. The only items marked off included his cognition, diagnosis and physical ability to ambulate. This was the only elopement assessment completed from admission until 02/23/26. Review of the plan of care dated 02/06/26 revealed Resident #75 had impaired cognitive function/dementia or impaired thought process related to Alzheimer's and dementia. It was updated on 02/23/26 (after surveyor intervention) and changed to also state the resident was at risk for elopement due to poor cognition. Resident resided in the secured unit for a structured environment. Interventions included the secured unit and to communicate with the resident, family and caregiver regarding the residents' capabilities and needs. The care plan dated 02/12/26 revealed the resident was a long-term resident. The resident's wife was not allowed to take the resident out of the facility and the daughter/POA (power of attorney) was to be contacted if this occurred. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 08 indicating impaired cognition and identified the resident required supervision or touching assistance with activities of daily living. Review of the progress notes dated 02/11/26 revealed the resident's daughter/POA requested the residents cell phone be taken away due to calling the police and continually calling about getting out of here. A note dated 02/12/26 from the unit manager at 10:30 A.M. revealed the resident went LOA (leave of absence) with his wife and stated the resident's daughter was notified. A progress note dated 02/12/26 at 12:00 P.M. stated this writer spoke with Resident #75's secondary POA (wife) regarding her taking resident on a LOA. Resident #75's wife stated they would return after lunch. The notes also stated although staff knew the resident was leaving with her, she needed to follow the LOA procedure and sign him out. A progress note dated 02/12/26 at 8:15 P.M. revealed the nurse was notified the resident was on his way to the hospital due to aggressive behaviors. A follow up progress note on 02/12/26 at 10:20 P.M. revealed the hospital informed the facility that the resident would be returning around 11:30 P.M. to the facility. A progress note dated 02/12/26 at 11:50 P.M. revealed the resident returned to the facility. The POA (daughter) informed staff that resident was not to leave the facility with anyone and the male visitor (who he had left with) was not to visit with the resident at (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	all. The POA would come in on 02/13/26 to discuss concerns with management. The progress note dated 02/13/26 at 1:01 P.M. revealed a care conference was held with the POA (daughter). The progress notes revealed no documented evidence that Resident #75 left the facility with an unknown male on 02/12/26. Review of the hospital record dated 02/12/26 revealed the resident came to the emergency department due to aggression. It stated Resident #75 was removed from a locked Alzheimer's unit with a friend against the POA (power of attorney)'s wishes and taken home. Upon arrival he became increasingly agitated and once family stated they would take him back, Resident stated I'll just kill myself. The hospital record stated he remained agitated upon arrival to the hospital and was cleared to return to the facility around 11:00 P.M. Review of the medical record found a special instruction dated 02/13/26 at 12:32 P.M. stating must get authorization from daughter for any visitor other than his wife and daughter was the only person authorized to take the resident off the unit. Review of the undated facility timeline of events revealed a friend visited and asked to accompany the resident outside to assist in gathering laundry, and the Unit Manager (UM) agreed. Resident #75 got into the friend's vehicle without notifying staff. Staff spoke with Resident #75's wife who was with him at lunch and also spoke with the daughter who reported he had left town and she requested the facility make a wellness check with the police department to get resident to return to the facility. Interview on 02/23/26 at 10:07 A.M. with Licensed Practical Nurse (LPN) #285 revealed the memory care unit had a dedicated nurse and two aides on day shift. The LPN revealed Resident #75 had recently admitted and had been observed to walk the hallways and press on the locked exit doors. The LPN revealed the resident had eloped on 02/12/26 when a male visitor took him out of the facility without the resident's daughter/POA's knowledge. The LPN revealed facility staff should be checking in the medical record to determine who the main contact person was and if they were not listed, they were not allowed to take resident off the memory care unit without approval from the POA. The LPN confirmed Resident #75 left with an unapproved person with a plan to go to the parking lot and they ended up leaving the facility parking lot and driving away without memory care staff knowing the whereabouts of Resident #75. The LPN was concerned as the resident had packed up his belongings and went outside without staff supervision. The LPN also revealed the documentation in the medical record did not give an accurate portrayal of the incident and downplays that the resident had been missing. Observation on 02/23/26 at 10:40 A.M. found a sign/note taped to the nursing station desk stating staff must check in the residents medical record and get approval from the POA. Interview on 02/23/26 at 10:25 A.M. with Resident #75 revealed he had been at the facility for a while and stated he had called a friend to get him out of here. He confirmed his friend came and said this place was horrible and agreed to sneak me out. He reported they packed up his belongings and just walked out and was unsure if the friend spoke with staff prior to them leaving. He stated he left [NAME] and went and visited some friends. Resident #75 reported he did not remember returning to the facility or going to the hospital and reported he was admitted for his dementia diagnosis and memory issues. Interviews on 02/23/26 from 11:04 A.M. to 11:20 A.M. with Certified Nursing Aide (CNA) #166 and Registered Nurse (RN) #237 revealed the assigned nurse took a break and Unit Manager (UM) #244 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was covering for her when Resident #75 exited the memory care unit. They reported the friend asked UM #244 about taking Resident #75 to the parking lot to exchange some clothing items and resident was allowed by UM #244 to go outside with a duffle bag of belongings. When staff later went to gather residents for lunch they were unable to find Resident #75. Staff started looking for the resident and informed the nurse and unit manager that he never returned from being outside with the friend. Staff also checked the parking lot and found the friends vehicle was also gone. They started looking for resident and calling family. They found the resident had been gone for about 30 to 60 minutes before they started looking for him. They revealed staff reached out to Resident #75's POA (daughter) to let her know a male visitor had taken the resident out of the facility and the daughter reached out and found Resident #75 was at lunch with his wife. They reported the resident should not have been allowed outside the facility with a male visitor without approval from the POA. They reported Resident #75's wife was not in the facility and was not seen by these staff members on 02/12/26 prior to Resident #75 leaving the facility property. Interview on 02/23/26 at 11:47 A.M. with CNA #165 revealed she heard the friend ask UM #244 about taking the resident to the parking lot to exchange some items at his vehicle. She reported the UM confirmed the resident would be brought back from the parking lot and the friend agreed the resident would be back once items were exchanged. The CNA revealed the UM approved and instructed her to use the door code and let them off unit and the CNA reported if a member of the management team said it was okay she thought it was fine. The CNA reported it had been some time (estimated at 30 minutes) without seeing Resident #75 and he did not return, so she informed the nurse and UM who stated, Oh crap. CNA #165 reported residents should not be allowed off the unit unless they had approval from the POA. Interview on 02/23/26 at 12:05 P.M. with LPN #124 revealed Residents daughter had informed staff prior to the incident on 02/12/26 that resident was not to leave the unit without anyone but her. LPN reported she was unsure if this was documented in the record but stated it was known to several staff members. LPN revealed she would consider this an elopement due to the staff not knowing where resident had gone for a period of time and he had made it clear he wanted to leave and get out of facility. The LPN revealed residents POA (daughter) informed her the facility called and asked her who resident had left with, and at the time she was not aware of the friend visiting or taking him out of the facility. LPN confirmed their were also issues with the resident having a phone and calling friends and family to get him out of the facility. LPN confirmed the incident documentation in the medical record was not accurate as a male visitor came in and took resident off property without the memory care staff knowledge and the facility management documented his wife took him on a LOA. Interview on 02/23/26 at 12:20 P.M. with Unit Manager (UM) #244 reported the resident's friend had asked to take him to his vehicle to exchange some items and was supposed to return to the facility. She stated she was informed shortly after that resident had not returned to the memory care unit and they searched the parking lot and found the resident and visitor had left. They called the residents wife and she had reported she was at lunch with the resident and they would return him to the facility. The UM revealed the facility completed staff education and added a special instruction in Resident #75's medical record that he was not to leave with anyone but the POA (daughter) and the only visitors were to be the wife and daughter, unless approved by family. Interviews on 02/23/26 from 12:35 P.M. to 3:20 P.M. with Administrator #188, Unit Manager #244 and Director of Nursing #272 revealed Resident #75 went on a leave of absence with his wife. They would not acknowledge the concern of the resident leaving with a visitor without memory care staffs knowing he was leaving and without contacting the POA. The UM reported it was about 10 to 15 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	minutes later when resident did not come back inside, staff alerted the bosses who also looked at the parking lot and did not see Resident #75 or the male visitor. At that time they contacted Resident #75's wife who reported the resident was with her at a restaurant. The Unit Manager revealed when she left around 7:00 P.M., Resident #75 still had not returned. The Administrator reported she entered the special instructions in the medical record when the resident returned to the facility and after speaking with the residents POA (daughter). They stated facility management staff knew the resident's wife was in the car and stated he was not missing but acknowledged if they knew, the facility would not have needed to call and find him, and staff on the memory care unit should have known the resident's wife was present prior to him leaving. They reported the resident left with a capable adult, but also acknowledged that the individual asked for the resident to come out to exchange belongings and would return, and instead took off with the resident without informing staff. The Administrator also stated the facility contacted the police for a wellness check to get the resident back to the facility. They confirmed the resident was out of the facility for about 12 hours. The Administrator and Director of Nursing (DON) confirmed the facility had completed an elopement assessment upon admission and they would update it quarterly. They reported they did not expect staff to repeat the assessment when changes to resident's conditions occurred and/or changes in behavior. They reported they would not have completed an updated assessment even after the resident stated pressing on doors, pacing the halls and calling family and friends to get him out of here. They also confirmed the care plan was not updated about his elopement risk until the state survey 02/23/26 brought up concerns and also confirmed changes in interventions were not initiated when the resident started showing risky behaviors for elopement but were initiated after the incident occurred. The Administrator acknowledged the elopement risk assessment and care plan were not timely updated. Interview on 02/23/26 at 2:44 P.M. with Ombudsman #600 revealed they were completing an investigation related to elopement concerns of Resident #75. They reported being onsite 02/18/26 and were waiting for the facility to provide a timeline/investigation related to the incident where Resident #75 was allowed to leave the locked memory care with a friend/unknown individual without the POA (daughter) approval. Interview on 02/23/26 at 2:52 P.M. with Social Services (SS) #640 revealed she saw Resident #75 leaving the facility and getting in a car with a male visitor. She stated the residents wife was seen in the car and she observed them drive out of the parking lot. SS #640 revealed knew Resident #75 was from the memory care unit and did not inform staff of this when resident left. She also revealed she was not aware staff did not see Resident #75's wife on the memory care unit when he left. Review of facility policy titled Signing Residents Out, dated 08/2024, revealed all resident leaving the premises must be signed out. This deficiency represents non-compliance investigated under Master Complaint Number 2748011.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of facility policy, the facility failed to ensure weight measurements were verified after a significant weight change. This affected one (Resident #22) out of four residents reviewed for weight loss. The facility census was 67. Findings include:Review of the medical record for Resident #22 revealed an admission date of 10/06/23 with diagnoses including acute and chronic respiratory failure, chronic obstructive pulmonary disease (COPD), morbid obesity, hypertensive heart disease with heart failure, acute pulmonary edema, peripheral vascular disease and shortness of breath.Review of the care plan dated 12/17/24 revealed the resident was at risk for altered nutritional and hydration status with interventions to administer medications as ordered, monitor for malnutrition, obtain laboratory (lab) and diagnostic work as ordered, provide prescribed diet and have the dietitian evaluate and make recommendations.Review of the annual Minimum Data Set 3.0 assessment completed 12/18/25 revealed the resident was cognitively intact, noted with significant weight loss without a prescribed weight loss regimen and was not receiving nutritional supplements.Review of the nutritional assessment dated [DATE] revealed the resident was at risk for nutritional and fluid imbalance due to obesity, COPD and sepsis. Interventions included monitoring weights, oral intake, skin and labs.Review of hospital records from 01/05/26 through 01/22/26 revealed the resident weighed 372 pounds on 01/22/26.Review of the weight summary revealed the resident weighed 372.2 pounds on 01/02/26 and 356 pounds on 02/01/26, a loss of 16.2 pounds or 4.35 percent in one month.Review of physician orders dated 02/03/26 revealed orders for weekly weights.Review of the weight report revealed the resident weighed 360.8 pounds on 02/10/26.Review of the dietary note revealed orders for weekly weights in place, weight loss was beneficial, and there were no new recommendations. Interview on 02/18/26 at 8:39 A.M. with the Director of Nursing confirmed the resident had a significant weight change after readmission from the hospital, triggered on 02/01/26.Interview on 02/18/26 at 11:52 A.M. with the Director of Nursing confirmed staff were expected to verify the weighing method and obtain a reweigh for a change of three to five pounds and confirmed that a reweigh was not completed after the 16.2ˆpound loss noted on 02/01/26. She stated weekly weights began on 02/03/26.Interview on 02/18/26 at 12:19 P.M. with Unit Manager #244 confirmed a reweigh was not obtained on 02/01/26. The Unit Manager stated the weight change was attributed to fluid overload resolved during hospitalization and believed medications contributed to the loss, so a reweigh was not requested. The Unit Manager confirmed the facility policy required a reweigh for changes of 3 to 5 pounds and confirmed the most recent hospital weight was 371 to 372 pounds on 01/22/26, and confirmed the dietitian assessed the resident six days later and implemented weekly weights on 02/03/26. Review of the weight management guidelines policy revealed a reweigh will be obtained when there is a weight variance of plus or minus five pounds.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, record review, and review of facility policy, the facility failed to ensure supplemental oxygen was administered per physician order. This affected one (Resident #22) out of five residents identified as receiving oxygen administration. The facility census was 67.Findings include:Review of the medical record for Resident #22 revealed an admission date of 10/06/23 with diagnoses including acute and chronic respiratory failure, chronic obstructive pulmonary disease (COPD), morbid obesity, hypertensive heart disease with heart failure, acute pulmonary edema, peripheral vascular disease and shortness of breath. Review of the annual Minimum Data Set 3.0 assessment completed 12/18/25 revealed the resident was cognitively intact and was receiving oxygen therapy. Review of the physician order dated 12/31/25 revealed the resident was ordered oxygen at 3 liters per minute by nasal cannula continuous inhalation. Review of care plan dated 02/03/26 revealed the resident had oxygen therapy related to COPD. Interventions included to give medications as ordered and monitor signs or symptoms of respiratory distress. Observation and interview on 02/10/26 at 9:20 A.M. of Resident #22 revealed the oxygen concentration administration level was at 4 liters nasal cannula, the resident denied any complaints of shortness of breath. Observation on 02/11/26 at 8:36 A.M. and 3:15 P.M. of Resident #22 revealed the oxygen concentration administration level was at 4 liters nasal cannula. Interview on 02/11/26 at 3:17 P.M. with Certified Nursing Assistant #287 confirmed Resident #22 was currently receiving oxygen at 4 liters. Interview on 02/11/26 at 3:21 P.M. with Licensed Practical Nurse #283 confirmed Resident #22 was currently receiving oxygen at 4 liters nasal cannula and denied having a physician order to increase oxygen as needed, however confirmed the physician was notified. Review of progress note dated 02/11/26 at 3:32 P.M. revealed the resident reported not feeling good, vitals were taken and an assessment was completed. The residents oxygen was increased to four liters via nasal cannula with oxygen [saturation] at 95%. Review of oxygen administration policy dated October 2022 revealed nursing should verify that there is a physician order, and review the physician order or facility protocol for oxygen administration.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to execute timely laboratory orders. This affected one resident (Resident #48) of two residents reviewed for laboratory services. The facility census was 67.Findings include:Review of the medical record for Resident #48 revealed the resident was admitted on [DATE] and had diagnoses including Huntington's disease, overactive bladder, and spinal stenosis of the lumbar region.Review of Resident #48's quarterly Minimum Data Set (MDS) 3.0 assessment submitted 01/22/26 revealed the resident had severe cognitive impairment.Review of Resident #48's progress notes written by Licensed Practical Nurse (LPN) #239 on 12/19/25 at 6:04 P.M. stated that Resident #48 was engaging in unusual behaviors. Examples included cleaning walls with tissue paper and attempting to put lotion on a sandwich. The progress note stated LPN #239 contacted Certified Nurse Practitioner (CNP) #616 and orders were received to check for a urinary tract infection (UTI).Review of Resident #48's medical record found that no order was placed for urine collection, analysis, or culture and sensitivity/susceptibility of pathogens isolated. Review of Resident #48's progress notes written by Licensed Practical Nurse (LPN) #239 on 12/25/25 at 10:19 A.M. stated that urine was collected for analysis and culture and sensitivity/susceptibility of pathogens. The laboratory reported receiving the urine specimen for analysis on 12/26/26 at 4:05 A.M.Review of Resident #48's laboratory results reported urinalysis results on 12/26/25 at 12:17 P.M. and urine culture and susceptibility results on 12/29/25 at 10:47 A.M. The urine culture report included Escherichia coli (a bacteria) isolated from the sample.Review of Resident #48's care conference note from 01/02/26 at 3:00 P.M. by Social Worker #119 stated the resident had a slight urinary tract infection and that the doctor was aware.Review of Resident #48's progress notes written by Registered Nurse (RN) #621 on 01/05/26 at 11:20 A.M. stated the RN contacted Certified Nurse Practitioner (CNP) #616 regarding the culture and sensitivity/susceptibility results. Later in the afternoon on 01/05/26 at 3:12 P.M., orders from Physician #634 were entered into the medical record by Registered Nurse (RN) #621 for cephalexin (an antibiotic) tablet 500 milligrams (mg) to be taken twice daily for seven days to treat a UTI.Interview with LPN #239 on 02/17/26 at 10:18 A.M. confirmed the collection of Resident #48's urine sample on 12/25/25, was not timely.Interview with the Director of Nursing (DON) #272 on 02/17/26 at 1:52 P.M. confirmed there were no orders placed in the medical record for Resident 48's urine collection, analysis, or culture and sensitivity.