

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365381	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Wickliffe Country Place		STREET ADDRESS, CITY, STATE, ZIP CODE 1919 Bishop Rd Wickliffe, OH 44092	
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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, facility self-reported incident (SRI) review, facility policy review, facility investigation review, hospital record review, interdisciplinary team (IDT) summary review, and staff interview, the facility failed to protect the resident's right to be free from physical abuse by another resident. This affected one resident (Resident #162) of four residents reviewed for abuse. The facility census was 128. Actual harm occurred on 10/26/25 when Resident #162 sustained nasal bleeding and fractures of the maxilla and nasal bone after being struck by Resident #161. Resident #162 experienced significant injury, and the facility did not implement timely interventions or notify a physician despite documented increases in Resident #161's behaviors on 10/18/25, 10/21/25, 10/24/25, and 10/25/25, failing to protect Resident #162 from foreseeable harm. Findings included: Review of the medical record revealed Resident #162 was admitted to the facility on [DATE] from a psychiatric hospital stay. The resident had diagnoses including but not limited to dementia, adjustment disorder, chronic obstructive pulmonary disease, type 2 diabetes mellitus, hypertension (high blood pressure), and cerebral infarction (stroke). Review of Resident #162's MDS 3.0 admission assessment dated [DATE], revealed a BIMS score of 03 (severe cognitive impairment), and no mood symptoms, psychosis, or behavior symptoms. The resident was supervision/touch assistance for all activities of daily living (ADL) apart from set up assistance for eating. The resident required supervision for ambulation (walking). Review of the medical record revealed Resident #161 was admitted on [DATE] with a history of traumatic brain injury and documented behavioral symptoms. On 10/13/25, nursing staff documented inappropriate resident room entry, taking other residents' belongings, wandering, and sexually inappropriate comments; however, the Medication Administration Record (MAR) documented no behaviors that day. On 10/14/25 and 10/16/25, progress notes again described sexual comments, difficulty with redirection, entering other residents' rooms, and taking food from others. On 10/18/25, multiple notes documented explicit sexual comments, invasion of personal space, and a verbal threat to slap another resident. Despite this escalation, there was no documentation of physician notification, and the MAR continued to record no behaviors for all shifts on 10/18/25. On 10/20/25, the resident's psychiatric nurse practitioner noted complaints from nursing about an unsafe environment, but no mention was made of the threat toward another resident. On 10/21/25, Resident #161 made additional verbal threats, including stating the intent to spit on staff, while also grabbing another resident's hand. Again, the MAR documented no behaviors for all shifts that day. Continued verbal aggression, sexually inappropriate statements, and inability to be redirected were documented on 10/24/25 and 10/25/25, including threats to smack and spit on another resident. There remained no evidence that the physician or administration was notified, the care plan was revised, or additional interventions were implemented to address Resident #161's (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 365381	Facility ID: 365381 If continuation sheet Page 1 of 40

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	increase in aggressive behaviors. Review of the progress notes for Resident #162, revealed on 10/26/25 at 10:27 A.M., the resident was struck in the nose from another resident (Resident #161) that resulted in bleeding. Compression and cold compress were applied, and an x-ray of the nose ordered. Review of the radiology (x-ray) of the facial bones results report dated 10/27/25, revealed possible minimally displaced fracture of the nasal bone. The MAR documentation every shift to monitor the presence or absence of behaviors noted no behaviors on 10/26/25 on the day shift. Review of the self-reported incident (SRI) form for alleged physical abuse, tracking #266795, dated 10/26/25, revealed Resident #161 had been agitated, stating he ran out of cigarettes and struck Resident #162 in the face. The initial report indicated Resident #162 suffered no harm, pain or mental anguish as a result of alleged incident. The final summary of the incident revealed Resident #162 had some bleeding from his nose, and x-ray was ordered that resulted in minimal displacement of Resident #162's nose. Further, the summary revealed Resident #162 suffered no harm and Resident #161 had no intent to cause harm to Resident #162. Review of the facility IDT summary for a resident-to-resident altercation, dated 10/26/25 and signed by the administrator on 10/26/25, revealed no mention of Resident #161 threats to physically hit another resident, taking food from another resident, create an unsafe environment for staff, or sexual inappropriate verbal aggression and threat to spit on a residents family member prior to the incident on 10/26/25. The report did indicate the actual nasal and maxillary fractures of Resident #162 diagnosed on [DATE]. Review of the facility IDT summary specific to Resident #161 dated 10/26/25 and signed by the administrator, revealed on 10/25/25, the nursing staff identified an increase in inappropriate behaviors, including foul language, sexually inappropriate comments, verbal harassment of residents, visitors, and staff, and threats directed toward another resident. Staff followed the care plan interventions, monitored the resident's behaviors, redirected as indicated, documented the incidents, and all interventions were effective. Review of Resident #162's NP #613 progress note dated 10/27/25 at 9:15 A.M. revealed the resident had swelling to the bridge of the nose and ecchymosis (bruising) under the right eye. The resident was sent to the emergency room for a computed axial tomography (CT) scan (specialized x-rays) to confirm if a fracture was present. Review of Resident #162's NP #163 progress note dated 10/28/25 at 12:19 P.M., and the hospital after visit summary dated 10/27/26, revealed a closed fracture of the maxilla (a bone of the mid face) and the nasal bone. Review of the staff statements, dated 06/29/26 at 3:30 P.M., provided by the DON, revealed a written statement by LPN #272 that Resident #161 was verbally aggressive to staff and redirected times three. Resident #161 became verbally aggressive to other residents. Resident #161 rose from his chair walking towards Resident #162. LPN #272 was assisting Resident #161 back to his chair and Resident #162 got up and ran towards Resident #161 and hit Resident #162. Review of the statement by CNA #247 (no date), revealed Resident #161 hit Resident #162 in the nose and the residents were separated with nurse assistance. Interview on 06/30/26 at 10:41 A.M. with LPN #272 revealed she was the nurse on the unit the day of the incident. Resident #161 called the staff expletive and [expletive] has a fat [expletive]. The staff were able to redirect him and he sat in a chair in the common area where other residents were at a table. Resident #162 was sitting on a couch across the room (approximately 25-30 feet) from where Resident #161 was sitting. Resident #130 told Resident #161 that he should not talk to the staff that way. Resident #161 responded, Shut up [expletive]. I'll slap the [expletive] out of you. LPN #272 revealed this is when Resident #162 got up from the couch and started walking towards Resident #161, to protect Resident #130. LPN #272 redirected Resident #162 back to the couch and while doing this, Resident #161 got up and ran towards Resident #162 and hit him. When asked if Resident #161 acted with intention to harm, LPN #272 stated she felt Resident #161 knew (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that food was prepared using methods that preserved its nutritional value, flavor, and appearance. This had the potential to affect all 124 residents who received meals from the kitchen, as four residents in the facility were not to receive nutrition by mouth (Residents #20, #30, #84, and #106). The facility census was 128. Findings include: Interview on 06/22/26 at 11:07 A.M. revealed Resident #45 stated the food was bland and had no taste. Interview on 06/22/26 at 12:04 P.M. revealed Resident #148 stated the food was horrible, the pork was tough to chew and cold. Review of the Day 5 diet spreadsheet for 06/25/26 revealed that the regular diet included chicken parmesan, spaghetti with marinara sauce, Italian blend vegetables, garlic toast, chef's choice fruit, 2% milk, and 1/2 cup of juice. Review of facility Dining Manager Chicken Parmesan recipe revealed the chicken parmesan was to have breadcrumbs, parmesan cheese, garlic powder and oregano coated on the chicken breast and the breast was to be seared. The chicken breast was covered with mozzarella cheese and marinara sauce. Review of facility Dining Manager recipe for Garlic Toast recipe revealed garlic powder and melted butter was to be brushed on each slice of bread and baked until toasted. Observation on 06/25/26 at 11:30 A.M. of the tray line revealed that the chicken breast served as Chicken Parmesan was not breaded and did not contain mozzarella cheese, as required by the facility's recipe. Observation on 06/25/26 from 11:30 A.M. to 12:32 P.M. revealed that the facility prepared a test tray to be observed on the last cart leaving the kitchen and delivered to the final unit. The last tray was passed as part of this observation. On 06/25/26, the food cart reached Unit E at 12:29 P.M., and all trays were passed by 12:32 P.M. Regional Dining Manager #618 obtained food temperatures, which measured 176 degrees Fahrenheit for the Italian blend vegetables, 171 degrees Fahrenheit for the Chicken Parmesan, 183 degrees Fahrenheit for the spaghetti noodles, and 43 degrees Fahrenheit for the milk. The vegetables were observed to be pale in color and soggy. The Chicken Parmesan did not contain mozzarella cheese or breading as required by the recipe, and the breadstick was not toasted and lacked any garlic flavor. The Administrator confirmed that the breadstick had no garlic taste and commented that she believed residents were supposed to receive a plain breadstick rather than a garlic stick. An interview on 06/25/26 at 12:30 P.M. with the Regional Dining Manager confirmed that the vegetables did not have a pleasing taste and the breadstick did not have a toasted texture. Observation on 06/25/26 at 1:29 P.M. revealed the main dining room had the dining menu posted for residents that revealed residents were to receive Chicken Parmesan, spaghetti with [NAME] sauce, Italian blend vegetables, and garlic toast with a chef choice of fruit. Interview on 06/30/26 at 10:42 A.M. revealed Resident #128 stated the food upsets his stomach and did not have a good taste. Interview on 06/29/26 at 9:22 A.M. revealed Resident #152 stated the food was not cooked well in the facility. This deficiency represents non-compliance investigated under Complaint Number 2984600, 2975249 and 2799605.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews, and record review, the facility failed to ensure that food was stored and prepared according to professional standards. This had the potential to affect all 134 residents who received meals from the kitchen as four residents had orders not to receive nutrition by mouth (Residents #20, #30, #84, and #106). The facility census was 128. Findings include: 1. Observation on 06/22/26 at 9:54 A.M. revealed that the reach-in coolers and food-contact surfaces had a sticky coating on the handles and doors, as well as a visible film of food residue on the surfaces. The sanitizing solution used to wipe kitchen surfaces was also not at the appropriate concentration. Temporary Food Service Manager #621 tested the sanitizing bucket and found it measured 100 parts per million (PPM). Manager #621 stated the concentration should be between 300 and 400 PPM to properly sanitize food-contact surfaces. Observation on 06/22/26 at 10:00 A.M. with Regional Dining Manager #618 revealed that the reach-in freezer contained an open clear bag of burgers exposed to air with no label or date. Frozen vegetables were found loose and scattered across the freezer floor. Additionally, a clear bag of cookie dough was observed open to air and was neither labeled nor dated. Observation on 06/22/26 at 10:30 A.M. of the ice machine revealed the overhead light was out, requiring the Regional Dining Manager to use his cell phone flashlight to view the inside of the facility's ice machine. Inside the machine, a black, debris-like substance measuring approximately six inches long and one inch wide was observed under the lid. The Regional Dining Manager confirmed the substance and stated the ice machine needed to be cleaned and the overhead light bulb needed to be replaced. Interview on 06/22/26 at 4:21 P.M. with [NAME] #622 verified he did not know the kitchen staff was to clean the ice machine. Review of facility policy titled, Production, Storage, and Dispensing of Ice, undated, revealed the ice dispenser would be cleaned and sanitized at least monthly as needed and the inside and outside of the machine would be cleaned. 2. Observation on 06/23/26 at 9:35 A.M. revealed food debris on the backsplash in the food-prep area, along with black grime buildup where the backsplash met the lip of the counter. Regional Dining Manager #618 verified the findings and stated the wall needed to be cleaned. Observation on 06/23/26 at 9:40 A.M. with Regional Dining Manager #618 revealed grease and burn stains on the back wall of the stove, as well as hardened grease on the side of the stove from previous drips. 3. Observation on 06/24/26 at 4:28 P.M. with the Regional Dining Manager #618 revealed the Unit B resident nourishment refrigerator contained a half-gallon of Silk soy milk with an expiration date of 05/14/26. Interview on 06/25/26 at 10:45 A.M. with the Assistant Director of Nursing #329 revealed she was not sure who was to clean the resident nourishment refrigerator on the units. Review of facility policy titled Food Safety and Sanitation, dated year 2017, revealed when a food package was opened the food item should be marked to indicate the open date and in order to assure the nutritional needs of the residents are met and that each facility maintained sanitary conditions. Review of facility Kitchen Cleaning List, undated, revealed ovens were to be clean inside and out, cooler doors wiped down all items dated and covered. Walls were to be wiped down. Review of facility policy titled Food Brought In From The Community, revised 01/06/25, revealed the facility permitted friends and family to provide food from outside the facility. Food and beverage brought in from the outside would be labeled with the resident's name and room number and dated by staff with the current date the item was brought in.		

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on record review and interviews the facility failed to ensure a licensed social worker worked full time in the facility. This had the potential to affect 127 residents in the facility. Findings include:Record review of timeline received from Senior Social Worker #615 revealed that the last day a licensed social worker worked full time in the facility was 02/10/26.Interview on 06/23/26 at 2:03 P.M. with Social Service Designee (SSD) #312 revealed that she had been working at the facility since 05/14/26 and will be testing for her social work license on 07/20/26. The senior social worker who had a licensed independent social work license had been overseeing work product. Interview on 06/25/26 at 12:46 P.M. with the Administrator revealed they could not provide specific times the Senior Social Work is scheduled to be in the building, they come as needed. Interview on 06/25/26 at 3:49 P.M. with the Senior Social Worker #615 revealed that they oversee SSD # 238 and #312. Senior Social Worker is available, but the social services designees do the day-to-day job duties. The Senior Social Worker revealed that they are in the building as often as the designees need them, but usually in the building three to five times a week.Interview on 06/29/26 at 9:30 A.M. with SSD #238 revealed they have been in the role for about a week. When they first started in March 2026 they were the SSD for a couple weeks and during those weeks they did care conferences, discharge planning, and minimum data set assessments. This past week the SSD #238 has been doing admission assessments and discharge planning.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure resident code statuses were accurately reflected in both the paper medical record and the electronic medical record (EMR). This affected six residents (Resident #1, #4, #7, #39, #43 and #152) of 35 residents reviewed for advanced directives. The census was 128. Findings include: 1. Review of Resident #1's EMR revealed an admission date of [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure with hypercapnia, acute and chronic respiratory failure with hypoxia, dependence on a respirator and heart failure. Resident #1 had an advanced directive physicians order dated [DATE] to be full code status which means all emergency life saving measures will be provided in the event of respiratory arrest or cardiac arrest. Review of the paper medical chart revealed there was nothing under the advanced directives tab or in the front of the chart. Interview on [DATE] at 1:55 P.M. with Licensed Practical Nurse (LPN) #302 confirmed the paper medical chart for Resident #1 did not contain advanced directives. 2. Review of Resident #4's EMR revealed an admission date of [DATE]. Diagnoses included COPD, dependence on a respirator, hypertensive heart and chronic kidney disease with heart failure and with stage five chronic kidney disease or end stage renal disease. Resident #4 had an advanced directive physicians order dated [DATE] to be full code status. Review of the paper medical chart revealed there was nothing under the advanced directives tab or in the front of the chart. Interview on [DATE] at 1:55 P.M. with LPN #302 confirmed the paper medical chart for Resident #4 did not contain advanced directives. 3. Review of Resident #7's EMR revealed an admission date of [DATE]. Diagnoses included COPD, DMII with diabetic peripheral angiopathy and anemia. Resident #7 had an advanced directive physicians order dated [DATE] to be Do Not Resuscitate Comfort Care-Arrest (DNRCC-Arrest) (a means a person would receive all emergency and medical care up until the time he or she experiences a cardiac or respiratory arrest, then all lifesaving measures would be stopped). Review of the paper medical chart revealed there was nothing under the advanced directives tab or in the front of the chart. Interview on [DATE] at 1:55 P.M. with LPN #302 confirmed the paper medical chart for Resident #7 did not contain advanced directives. 4. Review of Resident #39's EMR revealed an admission date of [DATE]. Diagnoses included malignant neoplasm of the brain, personal history of malignant neoplasm of the prostate and adult failure to thrive. Resident #39 had an advanced directive physicians order dated [DATE] to be full code status. Review of the paper medical chart revealed there was nothing under the advanced directives tab or in the front of the chart. Interview on [DATE] at 1:55 P.M. with LPN #302 confirmed the paper medical chart for Resident #39 did not contain advanced directives. 5. Review of Resident #43's EMR revealed an admission date of [DATE]. Diagnoses included acquired absence of kidney, chronic kidney disease stage three and obesity. Resident #43 had an advanced directive physicians order dated [DATE] to be full code status. Review of the paper medical chart revealed there was nothing under the advanced directives tab or in the front of the chart. Interview on [DATE] at 1:55 P.M. with LPN #302 confirmed the paper medical chart for Resident #43 did not contain advanced directives. 6. Review of Resident #152 EMR revealed an admission date of [DATE]. Diagnoses included hypertensive heart and chronic kidney disease with heart failure and kidney disease stage three, DMII and personal history of other malignant neoplasm of skin. Resident #152 had an advanced directive physicians order dated [DATE] to be full code status. Review of the paper medical chart revealed there was nothing under the advanced directives tab or in the front of the chart. Interview on [DATE] at 1:55 P.M. with LPN #302 confirmed the paper medical chart for Resident #152 did not contain advanced directives. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of the facility policy the facility failed to ensure a, clean, sanitary, homelike environment. This affected two resident's (Resident's #111 and #113) out of three reviewed for clean and sanitary resident rooms and had the potential to affect all residents who used the common area and wanted to know the time. The facility census was 128. Findings include: 1. Review of Resident #113's medical record revealed an admission date of 01/10/26 and diagnoses included emphysema, atrial fibrillation, hypertensive heart and chronic kidney disease with heart failure and end stage renal disease. Review of Resident #113's care plan dated 01/23/26 included Resident #113 had an ADL self-care, mobility, functional ability performance deficit related to his diagnoses. Resident #113 would maintain current functional status related to ADL's. Interventions included Resident #113 required substantial to maximal assistance from sitting to lying; Resident #113 required substantial to maximal assistance to roll left and right. Review of Resident #113's Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #113 was cognitively intact. Resident #113 used a wheelchair. Resident #113 required supervision or touching assistance for toileting hygiene, upper and lower body dressing and personal hygiene. Resident #113 required partial to moderate assistance for putting on socks and footwear. Resident #113 required supervision or touching assistance for the ability to transfer to and from a bed to a chair or wheelchair and the ability to get on and off a toilet or commode. Review of a Service Order from a roofing service company dated 06/15/26 included the roof technician inspected a leak area inside and MD #901 found the area on the roof. Multiple areas of flashing patches were pushing water. A hole was found from an animal at the firewall in the same area. The drain screen was off and the drain was holding water due to leaf debris, the drain was draining very slow and possible had a clog. Near the edge an area of coverstrip was found that was lifted and had a cut underneath. All areas were cleaned with membrane cleaner and all areas were repaired with flashing. Sealed all patches, cleared all drains of leaf debris on area of roof leak. There was lots of standing water on the roof. Review of a Service Order from a roofing service company dated 06/22/26 included the roof technician inspected leak area inside and leak area on roof and found multiple nail pops and rubber was cut at shingle to flat transition. Keyed out shingles and installed flashing in area of cut. Reinstalled shingles and caulked everything that was separated. Falling fascia trim near peak was repaired. Interview on 06/22/26 at 7:42 A.M. with Maintenance Staff (MS) #260 revealed the roof started leaking and the facility had the roof repair company out about a month ago. MS #260 indicated there was a storm on 06/21/26, he arrived to the facility on [DATE] at around 6:30 A.M. MS #260 revealed the ceiling was dripping on Resident #113's bed and it was hardly wet at all. MS #260 confirmed Resident #113's ceiling had a hole in it and water was leaking from the hole onto Resident #113's bed. Observation on 06/22/26 at 10:13 A.M. with Resident #113 revealed he was lying in bed on his left side and was pleasant and answered questions appropriately. Resident #113 indicated every night his bed became wet from the rain because the ceiling was leaking. Resident #113 pointed up to the ceiling to show where the ceiling was leaking. Observation revealed a hole in the ceiling, above Resident #113's bed and the hole was near the wall. The hole in the ceiling was approximately eight to twelve inches in diameter and the edges were wet and blackened. Interview on 06/24/26 at 11:25 A.M. of the Administrator revealed on 06/21/26 she was in the facility and there was heavy rain and the roof was leaking in the common areas on the nursing unit Resident #113 resided on. The Administrator revealed staff used buckets and blankets to (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	take care of rain water from the leaking roof. The roof was fixed on 06/22/26. The Administrator stated on 06/14/26 there was heavy rain, some leaking of the roof and the problem was fixed on 06/15/26 by 9:00 A.M. The Administrator stated Resident #113's sister called about his ceiling leaking on 06/22/26 and she had a conversation with Resident #113 about it. The Administrator indicated Resident #113 told her there was a day he woke up and water was dripping on him and staff pulled his bed away from the wall. Resident #113 told the Administrator that Maintenance Director (MD) #901 fixed the leak. The Administrator revealed there was a work order for Resident #113's ceiling repair but Resident #113 said nothing was actively falling or dripping on him. Interview on 06/25/26 at 6:31 A.M. with Certified Nursing Assistant (CNA) #387 revealed there was a heavy rain one to two weeks ago. The ceiling of the facility started leaking near the nurses station for the unit Resident #113 resided on. Resident #113 put his call light on and told CNA #387 his bed was wet and he did not know why. CNA #387 revealed the ceiling had a hole in it and was leaking over Resident #113's bed. CNA #387 indicated he told MD #901 that Resident #113's ceiling was leaking. The next day MD #901 told CNA #387 that he took care of the ceiling. It rained again and Resident #113's ceiling leaked again and CNA #387 put pads on the bed because the bed was wet, and told MD #901 the ceiling was still leaking. CNA #387 indicated the ceiling still looked like it leaked. CNA #387 revealed he offered to move Resident #113 to another room, but Resident #113 did not want to move. Interview on 06/25/26 at 1:32 P.M. with Resident #113 revealed his ceiling had the hole in it and it had been leaking for awhile and it leaked more than a couple weeks. Resident #113 indicated the ceiling had a hole in it since he moved to the room in February 2026. Interview on 07/01/26 at 9:48 A.M. of Maintenance Director (MD) #901 revealed he had only worked at the facility since March 2026 and was still getting acclimated to the facility. MD #901 indicated there was still a lot of maintenance work that needed done in the facility and he was doing his best to address it. 2. Review of Resident #111's medical record revealed an admission date of 02/25/26 and diagnoses included epilepsy, hepatic encephalopathy, and anxiety disorder, major depressive disorder and generalized muscle weakness. Review of Resident #111's admission Minimum Data Set assessment dated [DATE] included Resident #111 was cognitively intact. Resident #111 had upper body impairment on one side and required substantial to maximal assistance for toileting, upper and lower body dressing and was dependent for bed mobility. Observation on 06/30/26 at 1:30 P.M. with Resident #111 of his room revealed the nightstand next to the bed was not in good condition, was missing pieces of the finish and the drawers were crooked and did not open and close easily. The drawers also fell out of the nightstand easily when they were pulled open. Observation of the lamp in his room revealed there was a hole in the lamp shade. The wardrobe which held clothing was battered and was missing pieces of the finish. Resident #111 demonstrated that the window blinds did not close, stayed open all the time, and they were dirty and dust could be seen on the slats. Resident #111 indicated the toilet pressure was terrible and observation revealed it took two to three flushes to get the water to go down and flush properly. The toilet rocked when it was gently pushed on and rusty screws could be seen that attached the toilet to the floor. A light bulb was missing from the over the sink light, the bathroom mirror was chipped, and a vent cover in the ceiling was falling out of the ceiling on one side and there was a large amount of dust and dirt on the vent cover. Resident #111's room walls had black scuff marks on them. Resident #111 indicated he wished his room did not look so shabby and even his mother commented on the state of disrepair his room was in. Observation on 06/30/26 at 1:30 P.M. of the common room with Resident #111 revealed the large clock on the wall was not working. Resident #111 indicated the clock had not worked for at least a month and he really wished it showed the correct time. Resident #111 indicated he used the common area a lot and it was frustrating not to (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	know what time it was. Observation on 06/30/26 at 1:35 P.M. with Regional Director of Clinical Services (RDCS) #910 confirmed the clock was not working in the common area. RDCS #910 confirmed the nightstand next to the bed was beat up looking, was missing pieces of the finish and the drawers were crooked and did not open and close easily. The drawers also fell out of the nightstand easily when they were pulled open. Observation of the lamp in his room revealed there was a hole in the lamp shade. The wardrobe which held clothing was battered and was missing pieces of the finish. Resident #111 demonstrated that the window blinds did not close, stayed open all the time, and they were dirty and dust could be seen on the slats. Resident #111 indicated the toilet pressure was terrible and observation revealed it took two to three flushes to get the water to go down and flush properly. The toilet rocked when it was gently pushed on and rusty screws could be seen that attached the toilet to the floor. A light bulb was missing from the over the sink light, the bathroom mirror was chipped, and a vent cover in the ceiling was falling out of the ceiling on one side and there was a large amount of dust and dirt on the vent cover. Resident #111's room walls had black scuff marks on them. Interview on 07/01/26 at 9:48 A.M. of Maintenance Director (MD) #901 revealed he had only worked at the facility since March 2026 and was still getting acclimated to the facility. MD #901 confirmed the furniture in many resident rooms was beat up and needed replaced. New furniture was ordered, had been in the facility a few weeks but decisions had not been finalized about where in the facility the furniture was to used. MD #901 confirmed the clock in the common area was not working and was not showing the correct time. MD #901 revealed he could not fix the clock himself because it was too heavy and he would have to wait until someone could help him before he could fix it. Review of the facility policy titled Resident Rights and Facility Responsibilities dated 01/06/25 included residents had the right to a safe and clean living environment pursuant to the Medicare and Medicaid programs and applicable state laws and regulations prescribed by the public health council. This deficiency represents non-compliance investigated under Complaint Number 2799605, 2700113, 2699470.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interview, observation, and review of the facility policy the facility failed to ensure resident care conferences and revisions to comprehensive care plans were completed timely. This affected six residents (Resident's #6, #11, #61, #92, #140, and #159) of seven residents reviewed for care plan timing and revisions. Findings include: 1. Review of Resident #61's medical record revealed an admission date of 10/26/23 and diagnoses included Alzheimer's Disease with early onset, schizoaffective disorder depressive type, and generalized anxiety disorder. Review of Resident #61's Quarterly Minimum Data Set (MDS) assessment dated [DATE] included Resident #61 was cognitively intact. Resident #61 had no impairment of the upper and lower extremities. Resident #61 was independent for toileting and required supervision or touching assistance for upper and lower body dressing and personal hygiene, Resident #61 was independent to walk 150 feet in a corridor or similar space. Review of Resident #61's medical record including interdisciplinary care conferences (IDT) revealed she had a care conference on 08/28/25 and did not have another one until 06/25/26. Observation on 06/24/26 at 8:03 A.M. of Resident #61 revealed she was lying in bed and was dressed in jeans and a t-shirt. Resident #61 asked if she was going to make it. Interview on 07/01/26 at 12:08 P.M. of Senior Social Worker (SSW) #615 confirmed Resident #61 did not have an interdisciplinary care conference (IDT) completed from 08/28/25 through 06/25/26. Review of the facility policy titled IDT Care Conference and Documentation dated 01/06/25 included Interdisciplinary Care Conferences would be scheduled after admission and with Quarterly MDS of Significant Change MDS completion. Invitations would be sent to the residents and their family/responsible party. Each discipline would report on current resident status and progress toward goals during the conference. Goals would be reviewed and revised as needed and care plans would be updated. Resident and family/responsible party questions would be answered. Documentation would be in the electronic health record in the form of the IDT/Care Conference note or a narrative progress note. 2. Review of Resident #159's closed medical record revealed an admission date of 04/01/26 and diagnoses included fracture of the left patella, fracture around internal prosthetic left knee joint, end stage renal disease, dependence on renal dialysis and type two diabetes mellitus with diabetic chronic kidney disease. Resident #159 was discharged on 04/22/26. Review of Resident #159's admission Minimum Data Set assessment dated [DATE] included Resident #159 was cognitively intact. Resident #159 required substantial to maximal assistance with toileting hygiene, was dependent for bathing, and required partial to moderate assistance with personal (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hygiene. Review of Resident #159's medical record including interdisciplinary care conferences (IDT) did not reveal evidence Resident #159 had an interdisciplinary care conference while he resided at the facility. Review of Resident #159's IDT/Care Conference Note dated 04/07/26 revealed it was not completed. Interview on 07/01/26 at 12:08 P.M. of SSW #615 revealed the goal for completion of an admission care conference was the care conference should be completed within the first seven to ten days after admission. SSW #615 confirmed Resident #159 did not have an interdisciplinary care conference from 04/01/26 until his discharge 04/22/26. Review of the facility policy titled IDT Care Conference and Documentation dated 01/06/25 included Interdisciplinary Care Conferences would be scheduled after admission and with Quarterly MDS of Significant Change MDS completion. Invitations would be sent to the residents and their family/responsible party. Each discipline would report on current resident status and progress toward goals during the conference. Goals would be reviewed and revised as needed and care plans would be updated. Resident and family/responsible party questions would be answered. Documentation would be in the electronic health record in the form of the IDT/Care Conference note or a narrative progress note. 3. Resident #6 was admitted on [DATE] with relevant diagnoses that included depression, restlessness and agitation, and generalized anxiety disorder. Review of the Minimum Data Set (MDS) 3.0 quarterly Assessment (a federal tool for implementing standardized assessment and for facilitating care management in nursing homes) dated 06/04/26, revealed a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). The resident was independent in most activities of daily living (ADLs), with supervision/touch assistance with a shower/bath and set up assistance for putting on and taking off footwear. Medications coded in Section N of the MDS included antidepressants and opioid use. The antianxiety medication ordered on 05/29/26 was not coded. Review of Resident #6's physician medication orders included buspirone hydrochloride (HCL) tablet 5 milligrams (mg), one tablet by mouth twice a day for anxiety (an antianxiety medication), sertraline HCL 50 mg., one tablet by mouth one time a day for depression, and trazodone HCL 50 mg., give 75 mgs. by mouth at bedtime for insomnia, and oxycodone HCL tablet 5 mg., two tablets by mouth every 6 hours as needed for pain. The buspirone HCL 5 mg. tablet for anxiety was originally ordered on 05/29/26 by nurse practitioner (NP) #613. Review of the NP #613 progress notes dated 05/29/26, revealed Resident #6 complained of anxiety and not sleeping well, and agreed to begin the buspirone HCL medication. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Medication Administration Record (MAR) for May 2026 and June 2026, revealed the resident received the antianxiety medication (buspirone HCL) twice daily as prescribed by the physician. Review of the care plans revealed a care plan focus (initiated on 02/19/26) for use of psychotropic medications related to depression. The care plan focus and the interventions were not updated to reflect the use of the added antianxiety medication from 05/29/26. Review of the interdisciplinary team (IDT)/Care Conference notes revealed a care conference was held on 06/04/26. Interview on 06/29/26 at 11:00 A.M. with MDS nurse #601, revealed MDS nurses do not attend care conferences. Social service arranges the care conference schedule. MDS nurses update the care plans, attend daily report meetings, review the 24 reports. MDS nurse #601 verified the absence of the coding for the antianxiety medication on the quarterly assessment dated [DATE], and the care plan not updated for the use of the antianxiety medication. Review of the facility policy titled, Psychotropic Drug Use (revised 04/28/25), revealed a detailed procedure the ordering, assessment, gradual dose reduction (GDR), monitoring, and documentation of psychotropic medications. Review of the facility policy titled, IDT Care Conference & Documentation (reviewed 01/06/25), revealed care plans will be updated as part of the care conference. 4. Resident #11 was admitted on [DATE] with relevant diagnoses of schizoaffective disorder, bipolar disorder, type 2 diabetes mellitus, Crohn's disease, hyperlipidemia (high fat in the blood), and gastro-esophageal reflux disease. Review of the Minimum Data Set (MDS) 3.0 Quarterly assessment dated [DATE], revealed a BIMS was not assessed. Prior BIMS assessment (dated 12/04/25), revealed a score of 15 (cognitively intact). ADL assistance revealed the resident required set-up to substantial assistance depending on the task. Resident #11's physician medication orders revealed orders for buspirone HCL 5 milligram (mg) tablet (ordered 11/26/25), one tablet by mouth two times a day for anxiety (an antianxiety medication). Review of the care plan (dated 09/30/25) revealed a care plan for the use of psychotropic medications with potential for adverse reactions related to bipolar and schizoaffective disorder. The care plan interventions included such actions to monitor, document and report to the physician, signs and symptoms of depression unaltered by antidepressant medications. The care plan was not updated to reflect the diagnosis of anxiety or the antianxiety medication ordered on 11/26/25. Review of the interdisciplinary team (IDT) Care Conference notes dated 09/26/25 and 05/12/26, revealed evidence of a care conference. There was no quarterly care conference interdisciplinary team (IDT) care conference note for the MDS 3.0 Quarterly Assessment (dated 03/05/26) or progress (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	notes in the medical record verifying a care conference took place. Interview on 06/29/26 at 11:07 A.M. with MDS nurse #601, verified the buspirone HCL order, care plan findings, and the absence of a care conference or notes in the clinical record referring to a care conference for the 03/05/26 MDS 3.0 Quarterly Assessment. Review of the facility policy titled, IDT Care Conference & Documentation (reviewed 01/06/25), revealed care conferences were scheduled after admission and with Quarterly MDS or Significant Change MDS completion. Documentation was made in PointClickCare (PCC, the electronic medical record) in the IDT/Care Conference Note or a narrative progress note. 5. Resident #92 was admitted to the facility on [DATE] with relevant diagnoses of chronic obstructive pulmonary disease (COPD), aphasia (difficulty speaking), history of ischemic attack and cerebral infarction (stroke), and convulsions. Resident #92 was originally admitted on [DATE] to Memory Lane (secured unit). On 01/16/26, Resident #92 was moved to a nonsecured unit. Review of the facility documentation titled, Notice of Room, Roommate or Physician Change dated 01/16/26, revealed the resident was transferred from the secured unit to a nonsecure unit. Further, the physician order for a secured unit was revised on 01/16/26. Review of the medical record physicians orders dated 04/06/26 revealed an order for a Wanderguard (an electronic device to monitor potential wandering/elopement) placement, and staff to check placement and function every shift. Review of the Treatment Administration Record (TAR) for April 2026, May 2026, and June 2026, revealed the Wanderguard was marked off by licensed nursing staff every shift as in place and functioning. Review of the care plan dated 01/15/26, revealed a care plan that required the special care unit for the safety of the resident and others related to psychiatric diagnoses. The care plan was not updated to reflect the room change that occurred on 01/16/26 or the placement of the Wanderguard ordered 04/06/26. Review of the Minimum Data Set (MDS) 3.0 Quarterly assessment dated [DATE], revealed a BIMS score of 00 (severe cognitive impairment). ADL assistance revealed the resident was mostly independent with set up assistance for eating and oral hygiene, and supervision for toileting hygiene, and independent with ambulation. Interview on 06/23/26 at 11:34 A.M. with the MDS nurse #601, verified the care plan not updated to reflect the room change off the secured unit on 01/26/26, or the intervention of the placement of the Wanderguard ordered 04/06/26. Interview on 06/25/26 at 7:30 A.M. with LPN # #290, verified the Wanderguard was intact to Resident #92's right ankle. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of Resident #92 throughout the annual survey 06/22/26 through 07/01/26, revealed a Wanderguard in place to the right ankle. Review of the facility policy titled, IDT Care Conference & Documentation (reviewed 01/06/25), revealed care plans will be updated as part of the care conference. 6. Resident #140 was originally admitted to the facility on [DATE], with a current readmission date on 01/13/26 with relevant diagnoses of type 2 diabetes mellitus with hyperglycemia; bilateral surgical amputation, diabetic retinopathy; end stage renal disease (dialysis services); chronic respiratory failure with hypoxia, obstructive sleep apnea, chronic congestive heart failure (CHF), atherosclerotic heart disease, atrial fibrillation, obesity, depression, hyperlipidemia (high fat in the blood), gout, anemia, history of pulmonary embolism, and history of falls and diabetic foot ulcers. Review of the MDS 3.0 quarterly assessment dated [DATE], revealed a BIMS score of 15 (cognitively intact), with behavior indicators of depressive symptoms. The resident required substantial to full assistance with most ADLs and was non ambulatory due to bilateral lower extremity amputation. Review of the MDS 3.0 schedule in the medical record, revealed a MDS quarterly assessment on 10/22/25 and 01/22/26. There were no notes in the medical record progress notes to indicate a care conference took place on those dates. Further, review of the interdisciplinary (IDT)/Care Conference Notes, revealed the last care conference note on 08/14/25. Interview on 07/01/26 at 1:06 P.M. with the SSW #615, revealed it was up to the resident who was her own responsible party, to decide who got contacted for care planning. The social worker schedules the care conferences and there is a notification sheet about the appointment. For visually impaired residents, the resident is told verbally of the appointment date and time. The appointment is coordinated with the resident, and the conference is held in the resident's room or an alternate location if the resident has a roommate and does not want the care conference in the room. The social worker verified the MDS quarterly assessments for 10/22/25 and 01/22/26, and no documentation in the medical record of a care conference for those dates. The SSW #615 stated that sometimes there are paper copies of the care conference that were not uploaded to the medical record. On 07/01/26, the care conference notes for the 10/22/25 and 01/22/26 were requested from the Regional Director of Operations (RDO) #616. The RDO #616 verified in an email dated 07/01/26 at 1:44 P.M. that there were no paper interdisciplinary team (IDT)/care conference notes for Resident #140 at that time. Review of the facility policy titled, IDT Care Conference & Documentation (reviewed 01/06/25), revealed care conferences were scheduled after admission and with Quarterly MDS or Significant Change MDS completion. Documentation was made in PointClickCare (PCC, the electronic medical record) in the IDT/Care Conference Note or a narrative progress note. This deficiency represents non-compliance investigated under Complaint Number 2998550 and 2788113.		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility did not ensure residents received their ordered adaptive devices during meals as required. This affected five residents (Residents #04, #85, #89, #91, and #104) of the seven residents who had physician orders for adaptive feeding devices. The facility census was 128. Findings include: 1. Review of electronic medical record revealed Resident #04 was admitted to the facility on [DATE]. Medical diagnosis included type two diabetes, chronic obstructive pulmonary disease, dependence on respirator and renal dialysis. Review of Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed Resident #04's cognition was intact. Resident #04 needed set up assistance for eating. Review of Resident #04's physician orders dated 03/03/26 revealed Resident #04 was to use a plate guard (food bumper to help residents eat independently) two handled spouted cup and bendable built up utensils with every meal. Review of Resident #04's Plan of Care date created 06/23/26 revealed Resident #04 was to have a plate guard, black built up utensils, adult spouted cup. Observation on 06/23/26 at 12:31 P.M. during meal service revealed Diet Technician #619 delivered a meal tray to Resident #04 in his room that had a standard plate, cup and silverware. Interview on 06/23/26 at 12:31 P.M. with Resident #4 revealed he did not have his plate guard, two handled spouted cup and bendable built up utensils on his tray and stated he needed the equipment so he could feed himself. Interview on 06/23/26 at 12:32 P.M. with Diet Technician #619 verified Resident #04 had physician orders that required a plate guard, two handled spouted cup and bendable built up utensils at every meal and the adaptive equipment was missing from the tray. 2. Review of electronic medical record revealed Resident #85 was admitted to the facility on [DATE]. Medical diagnosis included type two diabetes, chronic obstructive pulmonary disease, dependence on respiratory and Parkinsons. Review of MDS 3.0 quarterly assessment dated [DATE] revealed Resident #85 needed assistance for set up of tray for eating and cognition was good. Review of electronic medical record physician orders dated 06/13/25 revealed Resident #85 was to use red foam tubing on eating utensils for all meals. Review of Resident #85's plan of care revised on 06/23/26 revealed Resident #85 was to have adaptive equipment red foam handle utensil for all meals. Observation on 06/23/26 at 12:45 P.M. with Registered Dietitian (RD) #620 revealed Resident #85 was observed in her room attempting to self-feed. Observation of the meal tray revealed standard utensils were provided instead of the required adaptive equipment. Interview on 06/23/26 at 12:46 P.M. with Registered Dietitian #620 verified Resident #85 had a physician order for red foam tubing on eating utensils for all meals and the tray ticket was noted a red foam handle was needed for all meals and verified Resident #85 received standard utensils. 3. Review of medical record revealed Resident #89 was admitted to the facility on [DATE]. Medical diagnosis included dementia, hemiplegia, gastro esophageal reflux, abnormal weight loss and major depressive disorder. Review of MDS 3.0 quarterly assessment dated [DATE] revealed severe cognitive impairment and set up assistance was needed to eat. Review of Resident #89's physician orders dated 03/06/25 revealed Resident #89 was to have a plate guard provided for all meals. Review of Resident #89's plan of care created on 06/23/26 revealed Resident #89 was to receive adaptive equipment that included a plate guard. Observation on 06/23/26 at 12:45 P.M. with RD #620 revealed #89 was in his room feeding himself without the prescribed plate guard attached. Interview on 06/23/26 at 12:46 P.M. with RD #620 verified Resident #89 was ordered to have a plate guard provided at all meals and meal tray was observed not to have the plate guard attached. 4. Review of medical record revealed Resident #91 was admitted to the (continued on next page)		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility on [DATE]. Medical diagnosis included convulsions, non-pressure ulcer of left foot, psychosis, amnesia, traumatic brain injury. Review of MDS 3.0 quarterly assessment dated [DATE] revealed Resident #91 had intact cognition and was dependent of staff for eating. Review of Resident #91's physician orders dated 06/06/24 revealed Resident #91 was to use a divided plate for all meals. Review of Resident #91's plan of care date created 06/12/14 revealed Resident #91 was to receive adaptive equipment of built up utensils and a divided plate. Observation on 06/23/26 at 12:48 P.M. with RD #620 revealed Resident #91 meal tray was in his room with a standard plate with no dividers provided. Interview on 06/23/26 at 12:49 P.M. with RD #620 verified Resident #91 had a physician order for a divided plate for all meals and Resident #91 was not provided a divided plate. 5. Review of medical record revealed Resident #64 was admitted to the facility on [DATE]. Medical diagnosis included dysphagia, cerebral infarction, depression. Review of MDS 3.0 quarterly assessment dated [DATE] revealed Resident #64 had moderate cognitive impairment and was independent with feeding self. Review of Resident #64's physician orders dated 10/30/25 revealed Resident #64 was to use a Provale cup only (a regulated limited flow cup to prevent choking). Review of Resident #64's plan of care date created 06/23/26 revealed Resident #64 was of have adaptive equipment that included a Provale Cup. Observation on 06/23/26 at 12:45 P.M. with RD #620 revealed Resident #64 was observed in his room feeding himself. Observation of Resident #64's meal tray revealed a standard cup was provided that had no handles or a lid. Resident #64 stated he usually received a different cup than the cup provided. Interview on 06/23/26 at 12:47 P.M. with RD #620 verified Resident #64 had a physician order for a Proval cup and did not have the cup in his meal tray. Review of facility policy titled Accuracy and Quality of Tray Line Service , undated, revealed all meals would be checked by the nutrition and food service personnel for accuracy and by the employees serving the meals prior to serving to the individual.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to ensure a dignified homelike environment by knocking on the resident's door before entrance. The affected one resident (Resident #149) with the potential to affect five additional residents (#10, #81, #20, #108, and #88) residents out of 22 residents observed for dignity. The census was 127. Findings Include: Review of the medical record for Resident #149 admitted on [DATE] with diagnosis of acquired absence of left leg below the knee, surgical amputation aftercare, posthemorrhagic anemia, severe protein calorie malnutrition, type two diabetes, hypertension, and pulmonary vascular disease. Resident #149 had a surgical wound to left leg and a wound on his coccyx. Resident #149 short-and long-term memory are intact and can make informed decisions. Resident #149 could make needs known. Observation on 06/22/26 at 2:13 P.M. revealed Certified Nursing Assistant (CNA) #341 did not knock on Resident #149's door when entering the room to provide care. Furthermore, observation on 06/23/26 from 8:24 AM to 8:27 AM revealed STNA #341 failed to knock on the door of Resident #10, #81, #20, #108, and #88 before entering. Interview on 06/22/26 at 12:11 P.M. with Resident #149 revealed they don't knock on my door before they come in. Interview on 06/23/26 at 8:27 A.M. with CNA #341 revealed she knew she needed to knock on doors before entrance but stated I'm moving fast to take care of people. This deficiency represents non-compliance investigated under Complaint Number 2721605 and 2700113.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record review, staff interview, and policy review, the facility failed to timely report an allegation of misappropriation to the stage agency. This affected one resident (Resident #140) of four residents reviewed for allegations of abuse, neglect, or misappropriation. The facility census was 128. Findings include: Resident #140 was originally admitted to the facility on [DATE], with a current readmission date on 01/13/26 with relevant diagnoses of type 2 diabetes mellitus with hyperglycemia; bilateral surgical amputation, diabetic retinopathy; end stage renal disease (dialysis services); chronic respiratory failure with hypoxia, obstructive sleep apnea, chronic congestive heart failure (CHF), atherosclerotic heart disease, atrial fibrillation, obesity, depression, hyperlipidemia (high fat in the blood), gout, anemia, history of pulmonary embolism, and history of falls and diabetic foot ulcers. Review of the Minimum Data Set (MDS) 3.0 quarterly Assessment (a federal tool for implementing standardized assessment and for facilitating care management in nursing homes) dated 01/22/26, revealed a Brief Interview of Mental Status (BIMS) score of 15 (cognitively intact), with behavior indicators of depressive symptoms. The resident required substantial to full assistance with most activities of daily living (ADL) and was non ambulatory due to bilateral lower extremity amputation. Review of the electronic medical record progress notes revealed on 02/15/26, Resident #140 was unresponsive, emergency protocol initiated, and sent to the emergency room via emergency medical services (EMS). Review of the electronic medical record progress notes January 2026 through 02/15/26, revealed no evidence related to a missing phone. Review of the [NAME] Police Incident/Offense Report #26-00438, revealed the mother of Resident #140 filed a lost property report of a cell phone on 03/12/26 at 10:30 A.M. that was missing since 02/15/26. According to the report, staff (unnamed) notified the mother that the resident's cell phone was wrapped in a blanket at the time of the resident's transport to the hospital. According to the mother, the hospital reported the phone was never at the hospital with Resident #140. Review of the facility Resident Grievance and Concern log July 2025 through May 2026, revealed no evidence of a missing phone for Resident #140. Interview on 06/22/26 at 9:50 A.M. with a family member, revealed Resident #140's mother filed a police report for Resident #140's missing cell phone after transfer to the hospital. The cell phone did not have the find my phone function activated. Interview on 06/24/26 at 12:57 P.M. with the Director of Nursing (DON) revealed Resident #140's daughter sent the DON a text message on 02/15/26 and reported the missing cell phone. The DON checked the resident room and did not find the cell phone and then notified the administrator the same day (02/15/26). The DON spoke with the daughter on 02/16/26 and 02/24/26 regarding the lost phone. The DON revealed the daughter only had concerns regarding the missing cell phone that had not been found. Interview on 06/24/26 at 12:42 P.M. with Administrator confirmed the DON did report the missing phone to her on 02/15/26, but she was waiting to see if the hospital found it, and verified she never submitted a self-reported incident (SRI) to the state agency. The Administrator revealed she opened an SRI for the missing phone on 06/24/26. Review of the facility policy titled, Abuse, Neglect, Exploitation and Misappropriation of Resident Property (reviewed 01/06/25), revealed it was the facility's policy to investigate all alleges violations of abuse, neglect, misappropriation of resident property, exploitation or mistreatment, including injuries of unknown source, submit a report to the Ohio Department of Health, and investigate the allegation. This deficiency represents non-compliance investigated under Complaint Number 2745982 and 2648399.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. Based on the review of the medical record, the facility self-reported incident (SRI) report, facility policy, the facility investigation report, hospital records, interdisciplinary team (IDT) summary, Resident #161 Administrator summary, and staff interview, the facility failed to thoroughly investigate resident to resident physical abuse between Resident #161 and Resident #162. This affected two residents (#161 and #162) of four residents reviewed for abuse. The facility census was 128. Findings included: Review of the progress notes for Resident #161 from 10/13/25 through 10/25/25, revealed the resident had behaviors of verbal aggression and physical threats towards staff and other residents, sexually inappropriate comments to staff, residents, and visitors, holding a resident's hand down and reaching for their food, and entering other resident rooms. Review of the self-reported incident (SRI) form for alleged physical abuse, tracking #266795 (dated 10/26/25), revealed Resident #161 had been agitated, stating he ran out of cigarettes and struck Resident #162 in the face. The initial report indicated Resident #162 suffered no harm, pain or mental anguish as a result of alleged incident. The final summary of the incident revealed Resident #162 had some bleeding from his nose, and x-ray was ordered that resulted in minimal displacement of Resident #162's nose. Further, the summary revealed Resident #162 suffered no harm and Resident #161 had no intent to cause harm to Resident #162. This report summary was inconsistent with medical record documentation and witness interview. Review of the facility SRI #266795 Resident to Resident facility investigation folder, revealed no staff statements regarding the incident. Review of the staff statements provided by the Director of Nursing (DON), revealed a written statement by Licensed Practical Nurse (LPN) #272 that Resident #161 was verbally aggressive to staff and redirected times three. Resident #161 became verbally aggressive to other residents. Resident #161 rose from his chair walking towards Resident #162. LPN #272 was assisting Resident #161 back to his chair and Resident #162 got up and ran towards Resident #161 and hit Resident #162. Review of the statement by CNA #247 (no date), revealed Resident #161 hit Resident #162 in the nose and the residents were separated with the nurse assistance. Review of the progress notes for Resident #162, revealed on 10/26/25 at 10:27 A.M., the resident was struck in the nose from another resident that resulted in bleeding. Compression and cold compress were applied, and an x-ray of the nose ordered. Review of the radiology (x-ray) of the facial bones results report dated 10/27/25, revealed possible minimally displaced fracture of the nasal bone. Review of the facility document titled, Physical Aggression Received report dated 10/26/25 for Resident #162, revealed an injury of epistaxis (nosebleed), but he denied pain. Review of the facility interdisciplinary team (IDT) summary, signed by the administrator on 10/26/25, revealed no mention of Resident #161 threats to physically hit another resident, hold a residents hand to take her food, create an unsafe environment for staff, or sexual inappropriate verbal aggression and threat to spit on a residents family member prior to the incident on 10/26/25. The report did indicate the actual nasal and maxillary fractures of Resident #162 that were diagnosed 10/27/25. Review of the IDT facility summary for Resident #161 and signed by the administrator on 10/26/25, revealed on 10/25/25, the nursing staff identified an increase in inappropriate behaviors, including foul language, sexually inappropriate comments, verbal harassment of residents, visitors, and staff, and threats directed toward another resident. Staff followed the care plan interventions, monitored the resident's behaviors, redirected as indicated, documented the incidents, and all interventions were effective. Further the summary identified physical aggression was a new behavior, with no known prior history of resident-to-resident physical aggression documented before the incident of 10/26/25. The summary (dated 10/26/25), included the hospital admission of Resident #161 on 10/27/25. Review of (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Resident #162's Nurse Practitioner (NP) #613 progress note dated 10/27/25 at 9:15 A.M., revealed Resident #162 had swelling to the bridge of the nose and ecchymosis (bruising) under the right eye. The resident was sent to the emergency room for a computed axial tomography (CT) scan (specialized x-rays) to confirm if a fracture was present. Review of Resident #162's NP #613 progress note dated 10/28/25 at 12:19 P.M., and the hospital after visit summary dated 10/27/26, revealed a closed fracture of the maxilla (a bone of the mid face) and closed fracture of the nasal bone Interview on 06/29/26 at 2:25 P.M. with the Regional Director of Operations (RDO) #616, confirmed there were no staff written statements relating to the event in the facility SRI investigation folder. Interview on 06/29/26 at 3:30 P.M. with the DON, revealed she keeps staff written statements for SRI's in a separate folder and provides the administrator with a copy. Review of the written statements revealed one LPN statement from LPN #272 statement and one CNA statement from CNA #247. A second CNA statement who worked the unit on the day of the incident was not taken. Further, the written statement by the LPN #272 revealed a different scenario than what was reported on the SRI. The CNA statement did not describe the actions of the resident prior to the incident, or interventions and supervision by the staff prior to the incident. Interview on 06/30/26 at 10:41 A.M. with LPN #272 revealed she was the nurse on the unit the day of the incident. Resident #161 called the staff expletive and [expletive] has a fat [expletive]. The staff were able to redirect him and he sat in a chair in the common area where other residents were at a table. Resident #162 was sitting on a couch across the room (approximately 25-30 feet) from where Resident #161 was sitting. Resident #130 told Resident #161 that he should not talk to the staff that way. Resident #161 responded, Shut up [expletive]. I'll slap the [expletive] out of you. LPN #272 revealed this is when Resident #162 got up from the couch and started walking towards Resident #161, to protect Resident #130. LPN #272 redirected Resident #162 back to the couch and while doing this, Resident #161 got up and ran towards Resident #162 and hit him. When asked if Resident #161 acted with intention to harm, LPN #272 stated she felt Resident #161 knew what he was doing. When Resident #161's mother visits, he was a different person. Interview on 07/01/26 at 8:45 A.M. with the DON, verified the findings of the nursing and nurse practitioner progress notes for Resident #161, the CT scan results of a fracture of the maxilla, the IDT summary, the physical aggression received report, and the inconsistency of the findings in the facility SRI report #266795. Review of the facility policy titled, Abuse, Neglect, Exploitation & Misappropriation of Resident Property (reviewed 01/06/25), revealed the investigation protocol included the resident, the accused, and all witnesses. Witnesses generally included anyone who witnessed or heard the incident, came in close contact with the resident the day of the incident (including other residents, family members); and employees who worked closely with the accused employee(s) and/or alleged victim the day of the incident. Further, follow up investigation procedure for Resident-to-Resident incidents were referred to the facility's interdisciplinary team to determine the appropriate intervention(s).		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the interdisciplinary team addressed all of Resident #99's discharge needs to ensure a safe discharge. This affected one resident (Resident #99) of one resident reviewed for discharge. Findings include: Resident #99's closed medical record revealed the resident was admitted to the facility on [DATE] due to a fall at home and her husband being admitted to the hospital. Resident #99 diagnosis consists of fracture of upper end of left humerus, emphysema, anxiety, hypertension, alcohol abuse, history of falling, and need for assistance with personal care. Resident #99 admission Minimum Data Set (MDS) assessment dated [DATE] revealed a brief interview for mental status (BIMS) score of six out of 15 which confirmed severe cognitive impairment. Resident #99 ambulated independently, but can be unsteady at times, and needed assistance toileting and getting in and out of bed. Resident #99 was an elopement risk, and a wander guard was implemented on [DATE] due to unaware of safety and trying to exit facility. Speech therapy conducted a BIMS assessment on [DATE] which scored 11 out of 15 and Resident #99 complained of decreased memory and confusion. Social service note dated [DATE] reveals Resident #99 can be impulsive, forgetful, confused and cognitive impairment was noted. Resident #99 husband passed away while Resident #99 has been in the facility. Social services completed an additional BIMS assessment on [DATE] which confirmed a score of 6 out of 15 noting dementia, disorganized thinking, and difficulty focusing attention. On [DATE] the final BIMS was completed under skilled nurse's notes and reveals that Resident #99 has ok long and short term memory, able to recall location of room and staff faces, made appropriate decisions regarding daily life, is not easily distracted, has organized thinking, and doesn't have an altered level of consciousness. Review of the Social Service Quarterly assessment dated [DATE] in section C psychosocial changes reveal no box checked for personal loss or change in relationships, yet in the dialog box revealed husband passed away and that the resident is happy to go home. Review of Resident #99's Discharge Patient Centered Plan and Instructions signed at discharge on [DATE] revealed the facility therapy department recommended 24/7 assistance upon discharge. The plan did not address the resident being discharged home alone since her husband died. Review of Resident #99's medical record revealed it was absent of a physician's order for discharge. Interview on [DATE] at 9:25 A.M. with Resident #99's brother-in-law (BIL) revealed that physical and occupational therapy hadn't started yet for Resident #99 and was waiting to hear back from the private duty aide vendor on when they would be able to start services. Interview on [DATE] at 10:56 A.M. with Licensed Practical Nurse (LPN)/ Social Service Designee (SSD) #238 revealed Resident #99's BIL was going to set up home health, private duty aide services, and have a neighbor check in periodically on Resident #99. LPN/SSD also revealed that they don't have the name or telephone number of Resident #99 neighbor. LPN/SSD #238 conveyed the BIL lives about two and a half hours away, but LPN/SSD #238 believed that Resident #99 would be able to manage at home. Interview on [DATE] at 1:20 P.M. with Therapy Director confirmed that the discharge: Patient Centered Plan and Instructions revealed a recommendation for 24/7 assistance from the therapy department. An interview to Resident #99 was attempted via telephone on [DATE] at 1:39 P.M. revealing a message saying the mailbox is full and you are unable to leave a message. Interview on [DATE] at 2:06 P.M. with LPN/SSD #238 revealed that she was unaware that therapy recommended 24/7 care for Resident #99 at discharge. Interview on [DATE] at 2:09 P.M. with Therapy Director revealed the therapy department recommended 24/7 assistance due (continued on next page)		

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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. Based on observation, interview, record review and review of the facility policy the facility failed to ensure activity outings outside of the facility were provided for the residents. This affected one resident (Resident #95) of two residents reviewed for activities. The facility census was 128. Findings include: Review of the Activity Calendar dated February 2026 through June 2026 did not reveal evidence outside outings were scheduled for the facility. The January 2026 Activity Calendar for the secured unit was provided and had an outing scheduled for the local library on 01/06/26 at 2:00 P.M. but the January 2026 Activity Calendar was not provided for the entire facility. Interview on 06/24/26 at 3:23 P.M. with Activity Director (AD) #619 revealed she and Activity Assistant (AA) #276 provided activities for the residents. AD #619 revealed she started working at the facility on 03/17/26 and provided a variety of activities for the residents. AD #619 revealed she did not drive the bus for outings outside the facility, and there was a problem getting the bus for outside activities for the residents. AD #619 indicated it had been brought up that the residents would like to have outings. AD #619 revealed the facility bus stayed at the facility but was borrowed by sister facilities a lot. The priority was taking residents to appointments, AD #619 had to work around appointments and there had been no outside outings since she started working at the facility on 03/17/26. AD #619 revealed she did not arrange or schedule appointments or outings because that was done by staff in central supply, but there was no one working in central supply right now. AD #619 indicated the residents asked her about going somewhere out of the facility. Interview on 06/25/26 at 12:05 P.M. with AA #276 revealed she began working at the facility in October 2025. AA #276 indicated when she first started working at the facility there were outside activities provided by the facility, and the person from central supply would schedule the outings. The person from central supply would be told what outings the residents wanted to do and she would schedule the bus for the day. AA #276 revealed the person from central supply left the facility around February of 2026 and since she left there was no one at the facility to schedule the outings. AA #276 indicated she did not remember who drove the bus for the outings outside of the facility. AA #276 revealed Former Activity Director (FAD) #960 left the facility around December 2025 or January 2026 and since then there had been no outside outings. Interview on 06/25/26 at 12:53 P.M. with the Administrator revealed the facility bus was shared with several sister facilities. The Administrator indicated she was managing the transportation schedule right now and a lot of residents had appointments and the use of the bus had to be prioritized for appointments. The Administrator stated the facility had a van and a bus and the van held one resident with a wheelchair and one other person and the driver. The bus could hold about three wheelchairs and a handful of residents. The Administrator confirmed the facility had not provided outings outside of the facility for a few months. The Administrator revealed the facility had a central supply position available and the central supply staff person coordinated transportation. Right now the Administrator and the Director of Nursing were coordinating transportation. Interview on 06/30/26 at 1:10 P.M. with Resident #95 revealed he was the Resident Council President. Resident #95 indicated the facility had not had any outings in a long time and residents wanted to go places like Wal-Mart, and Dairy Queen. Resident #95 stated again that they had not been anywhere in a long time and they wanted to go. Resident #95 indicated the residents spoke their opinions at the Resident Council Meetings and were told the facility would find a day to get them out to go somewhere. Resident #95 revealed the residents were told it would be on the calendar when there was an outing scheduled but no outings have been scheduled. Resident #95 indicated everyone had given up and stopped looking for an outing. Resident #95 stated going to Wal-Mart and Dairy Queen were simple outings and we need to get out of (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Wickliffe Country Place		STREET ADDRESS, CITY, STATE, ZIP CODE 1919 Bishop Rd Wickliffe, OH 44092	
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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	here! Resident #95 indicated the residents even liked just driving around and looking at the scenery and he loved to see the residents enjoying themselves. Review of the facility policy titled Resident Rights and Facility Responsibilities dated 01/06/25 included residents had the right of access to opportunities that enabled the resident, at the resident's own expense or at the expense of a third-party payer to achieve the resident's fullest potential, including educational, vocational, social, recreational, and habilitation programs.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure Resident #22's blood glucose levels will properly monitored before administration of insulin in accordance with physician orders and care planned interventions, and failed to ensure Resident #113's cardiac medication was ordered and administered properly. This affected two residents (Resident #22 and Resident #113) out of five residents reviewed for quality of care. Findings include: 1. Review of the medical record revealed Resident #22 was admitted on [DATE] with relevant diagnoses of type 2 diabetes mellitus with hyperglycemia (high blood sugar), chronic kidney disease, major depressive disorder, and hyperlipidemia (high fat in the blood). Review of the care plan (updated 05/09/24) for Resident #22, revealed a care plan for at risk for hyper/hypoglycemic reactions, abnormal lab values, diabetic ulcers, peripheral vascular disease, related to type 2 diabetes mellitus, chronic kidney disease, and use of antidiabetic medications. Relevant interventions included accu-checks (a type of blood glucose test) as ordered and give medications/insulin per physician order. Review of the Minimum Data Set (MDS) 3.0 Quarterly Assessment (a standardized assessment tool that measures health status in nursing home residents) dated 04/21/26, revealed a Brief Interview for Mental Status (BIMS) score of 05 (severe cognitive impairment), and activities of daily living (ADL) assistance ranging from set up assistance to dependent assistance for toilet hygiene, upper and lower body dressing, application of footwear, personal hygiene, and bed to chair transfer. Review of the active physician orders revealed medications for diabetes management included Lantus subcutaneous solution (ordered 03/25/26) 100 units/milliliter (ml). Inject 43 units subcutaneously every 12 hours for type 2 diabetes mellitus, Trulicity subcutaneous solution auto-injector 3 milligram (mg)/.05 ml, Inject 3 mg subcutaneously one time a day every Saturday for diabetes mellitus. Further, another medication ordered on 02/22/26 and discontinued on 06/22/26, revealed an order for Novlog FlexPen subcutaneous solution pen injector 100 units/milliliter (ml), Inject 21 units subcutaneously before meals for diabetes mellitus. Hold for blood glucose <150. Review of a new order on 06/22/26 revealed an order for Novlog FlexPen subcutaneous solution pen injector 100 units/milliliter (ml). Inject 24 units subcutaneously before meals for diabetes mellitus. Hold for blood glucose <150. Review of the Medication Administration Record (MAR) for April 2026, May 2026, and June 2026, revealed that in June 2026, blood glucose levels were documented with meals 06/01/26 through 06/22/26 12:00 P.M. Further review of the MAR on 06/22/26 at 4:00 P.M. 06/23/26 at 7:00 A.M., 11:00 A.M., and 4:00 P.M., 06/24/26 at 7:00 A.M., 11:00 A.M., and 4:00 P.M., and on 06/25/26 at 7:00 AM. and 11:00 A.M., revealed no documentation space on the MAR to record the blood glucose levels. Review of the nurses notes 06/22/26 through 06/25/26 and the medical record titled, Blood Sugar Summary log revealed the last blood glucose level documented was on 06/22/26 at 11:00 A.M. Review of Nurse Practitioner (NP) #613 progress note dated 06/25/26 for Resident #22, revealed the NovoLog insulin was increased from 21 units to 24 units three times a day due to high blood glucose (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	levels and an increase in A1C (a blood test that measures average blood sugar levels over the past 2 to 3 months) blood levels. Interview on 06/25/26 at 3:25 P.M. with the Director of Nursing (DON), verified the physician orders for insulin, the absence of blood glucose readings in the medical record vital sign section, the nurses notes, and the medication administration record (MAR) on 06/22/26 at 4:00 P.M., on 06/23/26 at 7:00 A.M., 11:00 A.M., and 4:00 P.M., on 06/24/26 at 7:00 A.M., 11:00 A.M., and 4:00 P.M., and on 06/25/26 at 7:00 A.M. and 11:00 A.M. The insulin order was corrected on 06/25/26 at 3:30 P.M. by the DON to include the blood glucose reading to the MAR after surveyor intervention. Review of the facility policy titled, Medication Administration General Guidelines (revised December 2019), revealed medications were administered in accordance with the written orders of the prescriber, and the documentation of dosing parameters such as vital signs and lab values in the electronic MAR system. 2. Review of Resident #113's medical record revealed an admission date of 01/10/26 and diagnoses included emphysema, atrial fibrillation, hypertensive heart and chronic kidney disease with heart failure and end stage renal disease. Review of Resident #113's care plan dated 01/15/26 and revised 01/23/26 included Resident #113 was at risk for decreased cardiac output and abnormal lab values related to atrial fibrillation, CHF (congestive heart failure), hyperlipidemia and hypertension. Resident #113 would not have signs and symptoms of decreased cardiac status as evidenced by no shortness of breath, no chest pain, vital signs within normal limits and no increased edema. Interventions included to give medications per physician order; monitor and document signs of shortness of breath and check Resident #113's oxygen saturation as needed and notify the physician or nurse practitioner if it was low; monitor for signs and symptoms of heart failure including dyspnea, shortness of breath, change in mental status, complaints of chest pain and increased edema. Review of Resident #113's Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #113 was cognitively intact. Resident #113 used a wheelchair. Resident #113 required supervision or touching assistance for toileting hygiene, upper and lower body dressing and personal hygiene. Resident #113 required partial to moderate assistance for putting on socks and footwear. Resident #113 required supervision or touching assistance for the ability to transfer to and from a bed to a chair or wheelchair and the ability to get on and off a toilet or commode. Review of Resident #113's physician orders dated 04/22/26 revealed Resident #113 had a cardiology appointment scheduled on 04/27/26 at 11:15 A.M. Review of Resident #113's Medication Administration Record revealed Resident #113 had a cardiology appointment scheduled on 04/27/26 at 11:15 A.M. Review of Resident #113's After Visit Summary for a cardiology appointment dated 04/27/26 revealed orders to increase Entresto (used to treat chronic heart failure) to 49/51 mg twice daily. Start taking sacubitril-valsartan (Entresto) 49/51 mg twice daily. Stop taking sacubitril-valsartan (Entresto) 24-26 (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mg tablet. Resident #113's heart failure, heart failure with reduced ejection fraction, NYHA class 111 (marked limitation, comfortable at rest, less than ordinary activity causes symptoms), atrial fibrillation (irregular heart beat), edema of both legs, body mass index (BMI) 50.0-59.9 adult. Review of Resident #113's Medication Administration Record (MAR) dated 04/27/26 through 06/30/26 revealed Resident #113 received Entresto (sacubitril-valsartan) oral tablet 24-26 mg two times a day for CHF (congestive heart failure). Resident #113's Entresto was not increased to 49-51 mg twice daily per physician orders on 04/27/26. Review of Resident #113's medical record including progress notes and physician orders dated 04/27/26 through 06/30/26 did not reveal evidence orders written on 04/27/26 by Resident #113's cardiologist to increase his Entresto to 49-51 mg twice daily were implemented or discussed with his primary care physician or his cardiologist. Review of Resident #113's After Visit Summary for a local hospital ED visit dated 06/19/26 included Resident #113's reason for the visit was SVT (supraventricular tachycardia) and the diagnosis was irregular heartbeat. Follow-up with your cardiologist, Resident #113 had a cardiology visit scheduled for 0707/26 at 11:40 A.M. Ask your physician about medications including sacubitril-valsartan 49-51 mg tablet, take one tablet by mouth two times daily. Review of Resident #113's medical record revealed no evidence the physician reviewed his cardiac medications as recommended in the hospital after visit summary. Observation on 06/22/26 at 10:13 A.M. of Resident #113 revealed he was lying on his left side in his bed with the head of the bed slightly elevated. Resident #113 was pleasant and answered questions appropriately. Interview on 07/06/26 at 9:06 A.M. of the Director of Nursing (DON) revealed Resident #113 had a cardiologist appointment on 04/27/26 and he did not return to the facility with physician instructions from the visit. The DON indicated Resident #113's physician instructions (After Visit Summary) were sent to his online portal that gave direct access to his personal health records and the facility did not have access to the online portal. The DON confirmed the facility had a responsibility to follow-up to obtain the physician instructions from the cardiology visit but it was also the responsibility of Resident #113 to make sure the facility received the physician orders from the visit. The DON revealed providers were not always aware a resident lived in a long term care facility. The DON indicated she was able to get Resident #113's cardiology appointment After Visit Summary physician discharge instructions dated 04/27/26 from Resident #113's daughter. Review of Resident #113's progress notes dated 07/06/26 at 9:55 A.M. revealed the DON placed a call to Resident #113's Cardiologist regarding his Entresto. Resident #113 was to continue the current order until his appointment on 0707/26. Interview on 07/06/26 at 10:33 A.M. with the DON revealed she reviewed Resident #113's hospital ED After Visit Summary on 06/19/26 and contacted Resident #113's cardiologist about the increased dose of Entresto and was told Resident #113 had a cardiology appointment on 07/07/26 and his (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications would be reviewed at the appointment. The DON confirmed on 06/19/26 when Resident #113 arrived at the facility from his ED visit he arrived with an After Visit Summary that had discharge instructions written including to ask Resident #113's physician about the medication sacubitril-valsartan 49-51 mg, take one tablet by mouth two times daily. The DON confirmed there was no evidence in Resident #113's medical record this was completed until she called Resident #113's cardiologist on 07/06/26. Review of the facility policy titled Medication Administration-General Guidelines dated 11/2021 included medications were administered only by licensed nursing, medical, pharmacy or other personnel authorized by state laws and regulations to administer medications. Medications were administered in accordance with written orders of the prescriber. This deficiency represents non-compliance investigated under Complaint Number 2998550, 2984600, 2788113, and 2700113.		

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F 0686 Level of Harm - Minimal harm or potential for 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 observation, interview, and record review, the facility failed to ensure pressure reducing interventions were in place at all times. This affected two residents (Resident #20 and Resident #149) of four residents reviewed for pressure ulcers. Findings include: 1. Review of the medical record for Resident #149 admitted on [DATE] with diagnosis of acquired absence of left leg below the knee, surgical amputation aftercare, posthemorrhagic anemia, severe protein calorie malnutrition, type two diabetes, hypertension, and pulmonary vascular disease. Resident #149 had a surgical wound to left leg and a pressure ulcer on his coccyx. Resident #149 short and long-term memory were intact and could make informed decisions and could make needs known. Review of the physician orders for Resident #149 dated 06/11/26 revealed a skin prevention order for a low air loss mattress to the bed and to check function every shift. Observation on 06/22/26 at 12:11 P.M. of Resident #149's room revealed a semiprivate room with a navy blue mattress in front of B bed that was not Resident #149's. Resident #149 was observed to have a below the knee (BTK) amputation. Interview on 06/22/26 at 12:11 PM with Resident #149 revealed that the mattress lying on the floor by the other bed should be on his bed, and it has been on the floor for about two weeks. Resident #149 said the mattress is supposed to help me with my wounds. Someone brought it in here about two weeks ago and never came back to put it on the bed. Observation on 06/23/26 at 11:00 A.M. revealed the mattress still on the floor in Resident #149 room. Interview on 06/23/26 at 11:03 A.M. with Registered Nurse (RN) #398 confirmed that the mattress has been on the floor for a week in Resident #149 room. Interview on 06/23/2026 at 11:15 A.M. with Regional Director of Operations revealed the mattress on the floor in Resident #149 room was supposed to be in use for Resident #149 since 06/11/26. 2. Review of the medical record for Resident #20 admitted on [DATE] with diagnosis of hemiplegia and hemiparesis following a cerebral infarction affecting left dominant side, acute chronic respiratory failure with hypoxia, type two diabetes with diabetic neuropathy, chronic obstructive pulmonary disease, severe protein calorie malnutrition, dementia, pressure ulcer of right heel stage three, pressure induced deep tissue damage of left heel, and adult failure to thrive. Record review of physician orders for Resident #20 dated 05/16/26 revealed a skin prevention order to offload heels while in bed as tolerated. Review of Resident #20's nurse practitioner note dated 06/22/26 at 11:45 A.M. revealed the resident was alert and oriented times one which was his usual. Observation on 06/30/26 at 8:43 AM revealed Wound Nurse Practitioner and Licensed Practical Nurse (LPN) #600 finished the sacral dressing change, left the room and did not offload Resident #20 heels before they left the room. Interview on 06/30/26 at 8:43 AM with Wound Nurse Practitioner confirmed Resident #20 heels not offloaded and should be and the pressure relieving boots were on top of wardrobe cabinet. This deficiency represents non-compliance investigated under Complaint Numbers 2975249, 2721605, and 2699470.		

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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, interview, record review, review of Occupational Therapy Evaluation and Plan of Treatment, and review of the facility policy the facility failed to ensure Resident #113's care planned fall preventive interventions. This affected one resident (Resident #113) out of three residents reviewed for falls. The facility census was 128. Findings include: Review of Resident #113's medical record revealed an admission date of 01/10/26 and diagnoses included emphysema, atrial fibrillation, hypertensive heart and chronic kidney disease with heart failure and end stage renal disease. Review of Resident #113's care plan dated 01/10/26 and revised on 01/12/26 included Resident #113 was a fall risk characterized by impaired mobility. Resident #113 would have no fall related injuries that required hospitalization through the review date. Interventions included bed in low position while in bed; encourage Resident #113 to call for assistance. Review of Resident #113's Occupational Therapy Evaluation and Plan of Treatment dated 01/12/26 included Resident #113 presented with impairments in balance, mobility, strength, and follow through. Due to the documented physical impairments and associated functional deficits, without skilled therapeutic intervention Resident #113 was at risk for falls, further decline in function, increased dependency upon caregivers, decrease in level of mobility and decreased participation with functional tasks. Resident #113 required partial to moderate assistance with shower/bathing and upper and lower body dressing. Resident #113 had falls six times in the past year with injury described as pain in bilateral lower extremities and lower back. Review of Resident #113's care plan dated 01/23/26 included Resident #113 had an ADL self-care mobility/functional ability performance deficit related to his diagnoses. Resident #113 would maintain current functional status related to ADL's. Interventions included Resident #113 required partial to moderate assistance with showering/bathing. Review of the facility incident log revealed Resident #113 had a fall incident on 04/10/26 at 4:30 P.M. Review of Resident #113's progress notes dated 04/10/26 at 5:04 P.M. included Licensed Practical Nurse (LPN) #223 answered the call light in the shower room and Resident #113 was sitting in a wheelchair and the shower chair had one leg broken. Resident #113 stated the shower chair broke and he got himself off the floor. Resident #113's vital signs including push and pulls were within normal limits. Resident #113 complained of pain from the right buttock down to the right knee. NP #613 was notified and x-rays were ordered and neuro checks were in place. All appropriate parties were notified. Review of Resident #113's Fall Review dated 04/10/26 at 6:30 P.M. included Resident #113 was a high fall risk. Resident #113 ambulated with problems and with devices and required partial physical support while standing. Resident #113 had three or more health conditions. Resident #113 complained of pain from the right buttock down to the right knee, the pain was new and it hurt a little bit. The immediate intervention was education was provided to call for help. X-rays were ordered and neuro checks were in place. All appropriate parties were notified. The facility IDT (interdisciplinary) team met for Resident #113's fall on 04/10/26. Resident #113 stated the shower chair broke. Resident #113's vital signs were within normal limits, no open or discolored skin areas noted. Neuro checks were started and were within normal limits. Immediate intervention was Resident #113 was assisted from the floor with one assist. The broken shower chair was red-tagged and all facility shower chairs were inspected for integrity. A new bariatric shower chair was ordered and Resident #113 was able to use an additional bariatric shower chair in the facility. The fall review did not address the resident being left alone in the shower room. Review of Resident #113's Quarterly Minimum Data Set assessment dated [DATE] revealed (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #113 was cognitively intact. Resident #113 used a wheelchair. Resident #113 required supervision or touching assistance for toileting hygiene, upper and lower body dressing and personal hygiene. Resident #113 required partial to moderate assistance for putting on socks and footwear. Resident #113 required supervision or touching assistance for the ability to transfer to and from a bed to a chair or wheelchair and the ability to get on and off a toilet or commode. Observation on 06/22/26 at 10:13 A.M. with Resident #113 revealed he was sitting in a wheelchair, and was pleasant and answered questions appropriately. Resident #113 revealed he weighed 450 pounds and needed a sturdy shower chair. Resident #113 indicated one day in April the shower chair broke while he was taking a shower and he fell on the floor. Resident #113 indicated his side is still numb from the fall. Resident #113 revealed when he fell he was by himself in the shower room, he activated the call light and he was on the floor 15 minutes before Licensed Practical Nurse (LPN) #223 came to help him up. Resident #113 stated he was lying on the floor and it was dirty. Resident #113 indicated the aides leave him by himself all the time in the shower room and he does not tell them he wants to be alone in the shower room. Interview on 06/25/26 at 6:31 A.M. with Certified Nursing Assistant (CNA) #387 revealed he was working on 04/10/26 when Resident #113 had a fall in the shower room. CNA #387 revealed the shower chair was only built to hold a certain amount of weight, it was a plastic chair, and the leg broke while Resident #113 was taking a shower. CNA #387 revealed Resident #113 took showers and did not have the aides in the room. CNA #387 indicated Resident #113 was fine in the shower room by himself and while he was showering on 04/10/26 CNA #387 took a 15 minute break. CNA #387 revealed when he returned from his break the chair had broken and Resident #113 was in his wheelchair inside the shower room. CNA #387 indicated the shower chair that broke was supposed to hold 600 pounds and after it broke Resident #113 requested to use the therapy bariatric chair because it was sturdier and had metal legs. CNA #387 revealed Resident #113 did not tell him how long he was waiting for the call light to be answered after the chair broke. Interview on 06/25/26 at 2:59 P.M. of Director of Rehab (DOR) #720 revealed Resident #113 was not currently receiving therapy and his therapy ended on 02/25/26. DOR #720 indicated one of the goals of therapy was for Resident #113 to bathe himself and this would include washing at the sink. Resident #113 required moderate assist for lower legs and feet. DOR #720 revealed she knew Resident #113 fell because the shower chair broke and she spoke with the nursing staff and the Administrator about ordering the appropriate equipment. DOR #720 revealed it was equipment failure and she recommended a bariatric shower chair. DOR #720 indicated Resident #113 borrowed the therapy bariatric shower chair until the bariatric chair ordered by the facility was available. Interview on 06/29/26 at 10:30 A.M. of the Director of Nursing (DON) revealed residents used the shower room when they wanted to take a shower and the level of assistance was documented in the resident care plan. The DON revealed residents should always be supervised when they were in the shower room. The DON indicated the aides should stay and supervise while the resident showered and the curtain could be pulled to allow privacy but the aides should always be in the room. The DON revealed Resident #113 had a fall in the shower room because the shower chair broke. The DON revealed Resident #113 used the therapy bariatric shower chair for his showers and there was also a bariatric shower chair which replaced the broken chair. The DON indicated she was not sure if there was an aide in the shower room when Resident #113 fell. Interview on 06/29/26 at 3:17 P.M. with Nurse Practitioner (NP) #613 revealed Resident #113 had a fall on 04/10/26 and she saw him on 04/13/26. NP #613 indicated Resident #113's right knee pain was chronic and he had it before the fall on 04/10/26, but she did not know his body was numb or he was having pain because he did not tell her he was having these issues. NP #613 revealed she was surprised he had not told her because he told her when he had a (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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NAME OF PROVIDER OR SUPPLIER Wickliffe Country Place		STREET ADDRESS, CITY, STATE, ZIP CODE 1919 Bishop Rd Wickliffe, OH 44092	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	problem.Review of the facility policy titled Falls-Clinical Protocol reviewed 01/06/25 included for an individual who fell, staff would attempt to define possible causes. A Fall Assessment and pain assessment were to be completed and the care plan would be reviewed and revised as appropriate.This deficiency represents non-compliance investigated under Complaint Number 3050538 and 2788113.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of the facility policy the facility failed to ensure Resident #113 had a comprehensive evaluation and care planned interventions for a significant childhood trauma. This affected one resident (Resident #113) out of three residents reviewed for trauma. The facility census was 128. Findings include: Review of Resident #113's medical record revealed an admission date of 01/10/26 and diagnoses included emphysema, atrial fibrillation, hypertensive heart and chronic kidney disease with heart failure and end stage renal disease. Review of Resident #113's Social Service admission assessment dated [DATE] included Resident #113 responded yes to the question have you experienced or witnessed a traumatic event in your life. Resident #113 described the trauma as a car accident in my life, and he would like to speak with a mental health professional. The assessment stated Resident #113's care plan reflected his needs and wishes related to trauma. Review of Resident #113's Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #113 was cognitively intact. Review of Resident #113's Social Service Quarterly assessment dated [DATE] included Resident #113 responded yes to the question have you experienced or witnessed a traumatic event in your life and described the trauma as homelessness. Resident #113 indicated he did not wish to speak with a mental health professional. Resident #113's care plan did not reflect resident's needs and wishes related to trauma. Review of Resident #113's care plan dated 01/16/26 and revised on 05/04/26 did not reveal evidence of a care plan related to trauma. Review of Resident #113's Psychiatric Note dated 05/26/26 included Resident #113 was seen on 01/27/26 for an initial psychiatric assessment and medication management. Resident #113 had trauma and revealed being shot at age [AGE] to 13, stabbed at age [AGE] to 16, and there was a severe motor vehicle accident involving his sisters during his adolescence. Resident #113 had a childhood assault in which he reported he was tied up, beaten, and severely injured by his peers. Resident #113 had an extensive history of childhood and adult trauma with ongoing guilt, emotional distress, anxiety, and depressive symptoms. Trauma-related symptoms were present; however, full PTSD criteria would be further assessed as treatment progressed. Resident #113's diagnoses included major depressive disorder, generalized anxiety disorder, insomnia disorder and unspecified trauma-and stressor-related disorder. Observation on 06/22/26 at 10:13 A.M. with Resident #113 revealed he was lying on his left side in his bed with the head of the bed slightly elevated. Resident #113 was pleasant and answered questions appropriately. Interview on 06/29/26 at 10:09 A.M. with Nurse Practitioner (NP) #613 revealed Resident #113 had a history of anxiety and she was not aware he had significant childhood trauma where he was stabbed, shot and tied up. NP #613 indicated Resident #113 never mentioned it when she talked to him. Interview on 06/29/2026 at 10:30 A.M. with the Director of Nursing (DON) revealed she was not aware Resident #113 had significant childhood trauma but it should be in his admission paperwork. The DON indicated she thought Social Services asked Resident #113 about his mental health including PTSD. The DON indicated she did not know Resident #113's psychiatric progress notes stated he had significant trauma as a child. Interview on 07/01/26 at 9:35 A.M. of Certified Psychiatric Nurse Practitioner (CPNP) #900 revealed she was still following up with Resident #113 to determine if she thought he had PTSD. CPNP #900 revealed she had not shared Resident #113's history with the staff but her psychiatric progress notes were available for staff to review. CPNP #900 indicated Resident #113 did not talk about his past traumas in depth, but discussed current stressors when she visits him. Interview on 07/01/26 at 12:40 P.M. with Senior Social Worker (SSW) #615 revealed when a resident was admitted there was a trauma (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	question on the social service admission form. There was also a trauma question on the Quarterly assessment and social services followed the MDS calendar. SSW #615 indicated the question was have you ever experienced a traumatic event in your life. SSW #615 indicated if a resident stated they had trauma then they were connected with psychiatric services if they requested it. SSW #615 revealed there should be a trauma care plan and she confirmed Resident #113 did not have a trauma care plan completed timely. SSW #615 indicated the care plan should include things like if triggers were identified and interventions were implemented and if there was a trauma but the resident did not want to do anything. Other disciplines like nursing could add to the care plan as needed. SSW #615 revealed she spot checked assessments done by the Social Services Designees, she did not spot check Resident #113's assessments dated 01/14/26 and 04/15/26 and Resident #113's trauma was just missed. Review of the facility policy titled Resident Rights and Facility Responsibilities reviewed 01/06/25 included residents had the right upon admission and thereafter, the right to adequate and appropriate medical treatment and nursing care and to other ancillary services that comprised necessary and appropriate care consistent with the program for which the resident contracted.		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to ensure effective care planned interventions were implemented to promote Resident #161's highest practicable physical, mental, and psychosocial well-being. This affected one (Resident #161) of one residents reviewed for behavioral health. The facility census was 128. Review of the medical record revealed Resident #161 was admitted to the facility on [DATE] from an acute care hospital stay. The resident had relevant diagnoses of adult failure to thrive, focal traumatic brain injury (TBI), restlessness and agitation, hypertension (high blood pressure), and anemia. Review of the Minimum Data Set (MDS) 3.0 admission assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 03 (severe cognitive impairment) and disorganized thinking. The resident was independent for all activities of daily living (ADL) apart from set up assistance for oral hygiene and putting on and taking off footwear. The resident was independent in ambulation (walking). No mood symptoms were present at the time of the admission assessment. Behavior symptoms included symptoms were not directed towards others, instances of rejection of care, and wandering. Relevant medications for Resident #161 included Seroquel (antipsychotic medication) oral tablet 25 milligrams (mg) one table by mouth every 6 hours as needed for agitation after 1:1, distraction, toileting, ruling out pain, and basic needs are provided and ineffective. Seroquel oral tablet 25 mg. one tablet by mouth two time a day for agitation, and Depakote (anticonvulsant medication used as a mood stabilizer) sprinkles 125 mg. oral capsule delayed release, give two capsules by mouth twice a day for behaviors related to traumatic brain injury (TBI). Review of the care plan for Resident #161 (created on 10/09/25), revealed the resident required the special care unit for the safety of the resident and others related to traumatic brain injury (TBI) with behaviors. Further review of the care plans revealed a care plan (initiated 10/14/25) for physical behaviors (urinating in trash cans, entering other residents' room without permission, touching their belongings, and opening the meal cart during mealtimes) related to poor impulse control, TBI, and verbalizing sexual inappropriate statements. An intervention included Monitor/document/report to MD of danger to self and others. (date initiated 10/14/25). The care plan was not updated since the initiation date of 10/14/25 and discontinued on 11/07/25 after the resident was discharged from the facility. Review of the progress notes dated 10/13/25 at 6:23 P.M. by Registered Nurse (RN) #631, revealed Resident #161 required redirection for inappropriate behaviors. Resident #161 entered other resident's rooms without permission, touched their belongings, and attempted to leave the unit. On 10/14/25 at 2:17 P.M. a progress note by Licensed Practical Nurse (LPN) #272, revealed the resident wandered into other resident rooms and at times was hard to redirect and made sexual comments toward staff. On 10/16/25 at 2:50 P.M., a progress note by LPN #272, revealed the resident made inappropriate sexual comments to staff and residents, was not redirectable at times, and took other residents meal trays and entered their room. On 10/16/25 at 9:20 P.M, a progress note by RN #365 revealed the was drinking other resident's cups of juice during dinner and verbal redirection was unsuccessful. On 10/18/25 at 7:16 A.M., a progress note by LPN #239, revealed the resident made explicit sexual comments and invasion of the personal space and was unable to be redirected. On 10/18/25 at 7:45 A.M., a progress note by Licensed Practical Nurse (LPN) #204, revealed the resident made inappropriate sexual comments and invaded her personal space. LPN #204 notified the police to make a harassment allegation. LPN #204 refused to work on the unit due to personal safety concerns and was reassigned to another unit. On 10/18/25 at 1:47 P.M., a (continued on next page)		

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Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to properly identify Resident #106's food allergies to ensure interventions were in place to provide the correct diet. This affected one resident (Resident #160) out of six residents reviewed for food. Findings include: Review of medical record revealed Resident #160 was admitted to the facility on [DATE]. Medical diagnosis included cognitive communication deficit, traumatic brain injury, post traumatic stress disorder, attention deficit hyperactivity disorder, autistic disorder, asthma. Allergies included Amoxicillin, diphenhydramine, fluoxetine, hazelnut, ketorolac, morphine, peanut oil, penicillin, peanuts, chocolate hazelnut flavor. Review of Resident #160's physician orders, dated 06/23/26, revealed Resident #160 was to receive a regular diet, regular diet texture thin liquid consistency. Review of Resident #160's physician orders, dated 06/24/26, revealed Resident #160 was to receive epinephrine zero point three milligrams solution auto injector intramuscularly every 24 hours as needed for severe allergic reaction. Review of Resident #160's admission Nursing assessment dated [DATE] at 2:07 A.M. revealed Resident #160 had no memory problems and comprehension was good. Review of Resident #160's admission Assessment and Baseline Care Plan dated 06/23/26 at 2:07 A.M. revealed the resident's food allergies were not listed with interventions to address the allergies. Review of Resident #160's Nutrition Assessment, dated 06/23/26 at 10:26 A.M., written by Diet Technician #617 revealed Resident #160 had food allergies to peanut oil, peanuts, chocolate hazelnut flavor, hazelnut and no cultural or religious preferences were noted. Diet Technician #617 wrote the kitchen was notified of food allergies. Interview on 06/24/26 at 2:00 P.M. during Resident Council meeting, revealed Resident #160 expressed concern he did not receive a meal ticket, his food allergies were not listed, and was concerned a cookie provided was a peanut butter cookie and he had a severe food allergy. Observation and interview on 06/25/26 at 12:50 P.M. revealed Resident #160's meal tray ticket did not have hazelnut listed as a food allergy and the Regional Dining Manager #618 stated he was not aware Resident #160 had a tree nut and peanut food allergy. Interview and observation on 06/25/26 at 1:00 P.M. revealed the Activities Director had a basket of peanuts available to resident to feed squirrels. The Activity Director #619 stated she was not aware if any resident had a peanut allergy. Interview on 06/29/26 at 11:46 A.M. with Diet Technician #617 revealed she performed Resident #160's admission nutrition assessment but did not speak to Resident #160 regarding his food allergies or the severity of his food allergies and did not update Resident #160 Baseline Care Plan. Diet Technician #617 revealed she would usually talk to the resident regarding a food allergy then notify the kitchen. This deficiency represents non-compliance investigated under Complaint Number 2975249.		