STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365388	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin Plaza Extended Care	3600 Franklin Boulevard Cleveland, OH 44113

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 observations, interviews and facility policy, the facility failed to ensure the environment was maintained in a safe, clean, homelike manner. This affected Resident #31, #46, #74, #95, #109, #128, #130, #141, #148 and had the potential to affect all 164 residents. 1.Observation on 02/19/26 at 8:42 A.M. revealed an unlocked cleaning supply closet on the second floor. Observation on 02/19/26 at 8:53 A.M. revealed Housekeeper #474 had entered the unlocked cleaning room on the second floor and had placed her cleaning cart inside and had left the door unlocked after exiting. Interview with Housekeeper #474 confirmed the cleaning closet had been unlocked and stated she did not have keys to unlock it. Observation on 02/19/26 at 9:07 A.M. revealed an unlocked cleaning supply closet on the third floor. Observation on 02/19/26 at 9:22 A.M. revealed an unlocked cleaning supply closet on the fourth floor. Interview on 02/19/26 at 11:34 A.M. with Housekeeper #388 revealed cleaning supplies were diluted when they were hooked up to the cleaning dispenser. Housekeeper #388 confirmed cleaning supply rooms had not been locked due to there was no keys to the supply rooms and rooms had remained unlocked and further confirmed the unlocked room on the third floor. Observation on 02/19/26 at 1:24 P.M. of fourth floor cleaning supply with Certified Nursing Assistant (CNA) #334 confirmed unlocked cleaning supply room on the fourth floor and CNA #334 stated cleaning supplies were to be secured at all times. 2. Interview and observation on 02/19/26 at 3:11 P.M. of Resident #130's room revealed the wall air-conditioning unit was extremely dusty. The wall behind Resident #130 bed floor trim was off the wall and the dry wall flaking off. Resident #130 revealed her bed did not work and was missing the electric plugins. Licensed Practical Nurse (LPN) #426 confirmed observation and said she would put a work order in. 3. Interview and observation on 02/24/26 at 1:53 P.M. to 2:25 P.M. with Maintenance Supervisor (MS) #335 revealed the following: -The 2nd floor women's shower room had a clogged toilet with feces and urine in it. A towel, hospital gown and socks were on the floor. Paint was peeling off above the shower and the ceiling had water stains. -The 3rd floor women's shower room had no cover for the light fixture and the bulbs were all out. Debris was flacking off light fixture. The tile was cracked under the shower head on the floor. Buildup of mildew and rust in the shower closest to the toilet. In the seated shower room there were 4 tiles (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	missing from the wall revealing a large hole in the wall you could see the wall structure through. Thick pieces of paint were peeling off above the tile. Water was visibly seen leaking from the ceiling and there was rust on the floor. -The 3rd floor men's shower room had a used towel on the shower bench. In the seated shower room [ROOM NUMBER] ceiling tiles approximately 3 feet by 6 feet had large brown water stains. One ceiling tile had a large bubble where it appeared it had stretched due to being filled with water. The standing shower to the right of the door had wall tiles missing and the ceiling tiles was wet to the touch. Interview with MS #335 at the time of observation revealed facility needs a new roof and that was causing so many issues with the ceiling tiles. Interview on 02/24/26 at 4:17 P.M. with Director of Nursing (DON) revealed the facility has new maintenance and housekeeping managers and the facility was getting a grant to replace the roof. Observation on 2/25/26 at 10:49 A.M. of 7 ceiling tiles by the 4th floor east nurses station with large brown water stains. Confirmed observation with Certified Nurse Assistance (CNA) #308. 4. Observation on 02/19/26 at 5:00 P.M. of first floor main elevator not working. The service elevator and the small elevator were still working and residents were able to use these elevators instead. Interview on 02/24/26 at 2:30 P.M. with Maintenance Supervisor #355 revealed he started at the facility six weeks ago and had been trying to figure out the issues with the elevators. He was waiting on a report for all the times the elevator repair company had been at the facility since January 2026. He said residents kick the door and it gets off track and this is what caused the issue on 02/19/26. Maintenance Supervisor #355 figured out one issue with the elevator was it being exposed to cold weather and was working on figuring out a solution. Interview on 02/25/26 at 11:03 A.M. with the Director of Nursing (DON) revealed there had not been a time that the elevators had all been out of order at the same time. The small elevator was down for a while because they replaced it but was now open again. The west elevator did break often and part of the issue is residents ramming into the doors with their electric wheelchairs. DON revealed the repair company comes out the same day or the next day. Residents were able to use the service elevator and they do not need staff to use the elevator. DON was not aware of any residents missing appointments due to the elevator being down. DON revealed the service elevator had not been out of order anytime that she can remember. Observation and interview on 02/25/26 at 5:00 P.M. of the west elevator not working again. Administrator revealed an elevator repair company was coming on 02/26/26 to fix the elevator. Administrator revealed they are working with the repair company to determine how to fix the elevator because it keeps breaking, is repaired and then breaks again. 5. Observation and interview on 02/25/26 at 3:18 P.M. with Maintenance Staff #356 revealed the following: -Resident #31's room had large amounts of paint chipping off the wall by the window and multiple ceiling tiles with large brown waters stains above the bed. -Resident #46's room had a large hole to the right of the wall air-conditioning unit that was stuffed with a towel. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #148's room had multiple ceiling tiles with large water stains. -Resident #95 and Resident #141's room had multiple areas in the floor with holes and large pieces of the floor tiles missing. 6. Interview and observation on 02/25/26 at 3:06 P.M. with Resident #74 revealed the light about her bed was not working and she had asked for it to be fixed multiple times. Resident had a yellow greenish splatter on the wall bed her bed. Resident #74 did not know what splatter was. The floor was dirty and had paint chipping on the wall to right of the window. Resident #74 had a standing fan that was dusty. Water stains on the wall from a leak and a hole in the drywall behind the bed was observed. Interview on 02/25/26 at 3:11 P.M. with Certified Nursing Assistant (CNA) #393 confirmed the observations. 7. Observation and interview on 02/26/26 at 9:23 A.M. of medication cart revealed the cart was dirty and had dried brown splatter on it. Medication Tech #396 confirmed observation. 8. Observation on 2/26/26 at 9:30 A.M. of Resident #128 and Resident #109's room reveled sink was leaking and had basin underneath with water dripping into it. LPN #320 confirmed observation and said she would put in a work order. This deficiency represents non-compliance investigated under Complaint Number 2655262, 2675466, 2645066, 2711653 and 2735835.

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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 interview, observation and record review the facility failed to ensure a comprehensive wound management system was in place to properly assess and treat Resident #52's new vascular wounds, and failed to ensure Resident #58's were clean and in good condition. This affected one resident (Resident #58) of four observed for assistive devices, and one resident (Resident #52) of two residents reviewed for skin impairments. Findings include:1.Review of Resident #52's medical records revealed an admission date of 10/09/25 with diagnoses including chronic ulcer of left foot, peripheral vascular disease (PVD) and muscle weakness.Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #52 had intact cognition. The assessment revealed Resident #52 was dependent (on staff) for toileting, and transfers, non-ambulatory and required maximum (staff) assistance for bed mobility.Review of care plan dated 01/16/26 revealed Resident #52 had a left heel vascular ulcer. Interventions included check dressing for placement during routine care, document wound status weekly and as needed and notify physician of changes, monitor wound for signs/symptoms of infection, and increase in size, administer treatments per orders and monitor skin surrounding alteration, heel lift suspension boots to be worn to bilateral feet and remove for bathing/hygiene and every shift skin checks. In addition, the plan of care revealed Resident #52 had self-care deficits related to limited mobility. Interventions included maximal assistance with bathing, personal hygiene and bed mobility and assistance with activities of daily living (ADL) on a daily basis.Review of weekly wound documentation dated 02/19/26 revealed Resident #52 had a vascular ulcer of the left heel that measured 3.0 centimeters (cm) in width by 2.0 cm in length and 0.1 cm in depth.Review of physician orders for February 2026 revealed Resident #52 was ordered heel lift suspension boots to be worn to bilateral feet at all times as tolerated, to be removed for bathing and hygiene and every shift skin checks. Treatment orders included cleanse left heel with normal saline, pat dry, apply santyl (topical enzyme ointment used to remove necrotic issue from chronic skin ulcers), cover with an absorbent dressing and wrap with kerlex every night shift. Review of Resident #52's medical record for February 2026 revealed skin checks were not documented every shit per physician orders and the plan of care and there was no evidence of showers/bathing provided.Review of a progress note dated 02/21/26 timed 3:39 P.M. authored by Licensed Practical Nurse (LPN) #320 revealed no new skin issues identified.Review of progress note dated 02/25/26 timed 11:15 A.M. authored by LPN #501 revealed no new skin issues identified.Review of weekly wound documentation dated 02/26/25 revealed Resident #52 had a left posterior vascular ulcer that measured 1.0 cm by 1.0 cm by 0.1 cm, left distal calf vascular ulcer that measured 2.5 cm by 1.0 cm by 0.1 cm, and a right heel vascular ulcer that measured 3.0 cm by 2.3 cm and unable to determine depth.Observation on 02/25/26 at 7:38 A.M. revealed a strong foul odor detected by Resident #52 that had become stronger upon approaching doorway. Resident #52 was sleeping at time of observation. Observation on 02/25/26 at 10:07 A.M. revealed the strong foul odor had continued in Resident #52's room. Observation of Resident #52's ADL care with Certified Nursing Assistant (CNA) #310 and CNA #336 confirmed the odor noted and the CNA #336 stated it smelled like a rotten wound. Observation revealed a Kerlix dressing to Resident #52's left heel that appeared to be clean and intact and was dated 02/25/26. Resident #52 had a pair of tattered, heavily soiled and flattened out heel boots placed under his feet and the left one was placed on upside down. CNA #310 and #336 confirmed the condition of Resident #52's boots and had removed them and stated they would throw them away. CNA #310 and CNA #336 had proceeded to roll Resident #52 on his right side and a circular opened red area was observed to his left mid-calf area. CNA #310 and CNA #336 stated they were not aware of the area prior to observation. Observation of Resident #52 on 02/25/26 at 11:00 A.M. with RN #353 (facility wound nurse) confirmed the area to Resident #52's left mid-calf area. RN #353 stated she had not been made aware of the area previously and stated she would contact the wound nurse (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	practitioner. RN #353 assessed the area and stated it was a skin tear and stated she was going to place a Xeroform and foam dressing to the area and the wound rounds were to be performed on 02/26/26.Review of progress note dated 02/25/26 timed 11:38 A.M. authored by Registered Nurse (RN) #353 revealed a new wound to Resident #52's left posterior calf that measured 1.5 cm by 1.0 cm and 0.1 cm in depth. Family and physician had been notified, and orders were to cleanse with normal saline, pat dry, apply xeroform (petroleum based wound dressing).Review of weekly wound documentation dated 02/25/26 revealed Resident #52 had a skin tear to the left posterior calf that measured 1.5 cm by 1.0 cm by 0.1 cm.Review of physician orders dated 02/25/26 revealed orders to cleanse left posterior calf and left distal calf with normal saline, apply xeroform and cover with a foam dressing every night shift.Interview on 02/26/26 at 9:44 A.M. with Wound Nurse Practitioner (WNP) #513 revealed RN #353 informed her of Resident #52's new wound on 02/26/26 when she arrived. Observation of wound care on 02/26/26 at 9:58 A.M. with WNP #513 and RN #353, upon initial assessment, Resident #52 had stated he was having pain in his right heel. WNP #513 had proceeded to remove Resident #52's sock and a large amount of Resident #52's skin was observed to have been seized to the sock and Resident #52's heel had a large half dollar size wound that was open and had a moderate amount of slough and necrotic tissue. WNP #513 had placed Resident #52's heel back down on the bed and had taken a few steps back and stated that was a new wound that she had not been made aware of. Further observation of Resident #52's sock revealed skin appeared to have been embedded into the fibers of the sock and a foul odor was detected. Further observation revealed WNP #513 had then proceeded to remove the Kerlix dressing from Resident #52's left foot and another new wound was observed to the residents left posterior calf that was approximately 4-5 inches above his chronic left heel wound. WNP #513 and RN #353 stated they had not been made aware of the new area. WNP #513 had proceeded to observe Resident #52's distal calf area that she had been made aware upon arrival to the facility on [DATE]. WNP #513 had assessed the new areas and had obtained measurements and stated the three new wounds were vascular wounds and had given orders for treatments to RN #353 at time of observation. WNP #513 revealed the wounds did not develop overnight but did not identify how the wounds occurred. Interview with Resident #52 at time of observation revealed he could not recall when he had last received a shower or when his sock had last been removed or foot had been cleaned. Review of progress note dated 02/26/26 timed 3:15 P.M. authored by RN #353 revealed a new wound to Resident #52's left distal calf that measured 2.5 cm by 1.0 cm by 0.1 cm, and a new wound to Resident #52's right heel that measured 3.0 cm by 2.3 cm and unable to determine depth due to 50% slough/necrotic tissue was present. Review of Resident #52's physician orders revealed orders to cleanse right heel with normal saline, apply santyl, cover with absorbent dressing and kerlex every night shift. Review of facility policy titled Skin Care Management revised 01/06/25 revealed residents with identified skin breakdown will have a documented skin assessment weekly including wound description and measurements, and treatments as ordered.2. Review of Resident #58's medical records revealed an admission date of 03/14/24. Diagnoses included contractures of the left upper arm and muscle weakness.Review of MDS assessment dated [DATE] revealed Resident #58 had intact cognition. Resident #58 was dependent with bathing, personal hygiene, bed mobility and transfers.Review of care plan dated 01/26/26 revealed Resident #58 was at risk for skin alterations related to contractures and hand splints. Interventions included examine skin before and after use of splinting.Review of Resident #58's current physician orders for February 2026 revealed orders to apply left hand/wrist splint and monitor for redness, open areas and may remove for bathing/hygiene.Observation on 02/19/26 at 11:30 A.M. revealed Resident #58 had his hand splint in his hand and had approached CNA #436 and asked her to apply it. Observation further revealed Resident #58's hand splint was heavily soiled with areas of dried dark colored debris. CNA #436 had proceeded to place Resident #58's hand splint on his left hand. Interview with CNA #436 after observation revealed she had observed Resident #58's hand splint to have been heavily soiled prior to placing it on his left hand and CNA #436 stated its been like that for a while.

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, hospital record review, facility policy review and interview, the facility failed to ensure staff provided Resident #168 with necessary, adequate and safe assistance during activities of daily living (ADL)/personal care to prevent fall with major injury, and failed to provide Resident #162 sufficient supervision and intervention to prevent the resident from exiting the facility unsupervised. This affected two residents (Resident #162 and #168) of three reviewed for accidents.Actual harm occurred on 09/14/25 at approximately 7:00 P.M. when Resident #168, who was cognitively impaired, a quadriplegic, and required two-person assistance with ADLs, was being changed (provided personal care) by one staff, Certified Nursing Assistant (CNA) #514, resulting in the resident falling out of bed and landing on the floor. Resident #168 was transferred to the hospital on [DATE], per family request, and was admitted with multiple fractures to his left pelvis, left hand fractures, a hematoma to left eyebrow and abrasions to his right knee and left ankle and toes as a result of the fall. Resident #168 remained in the hospital until 10/01/25 and did not return to the facility post-hospitalization. This affected two residents (Resident #162 and #168) of three reviewed for accidents.Findings include:1.Review of Resident #168's closed medical records revealed an admission date of 10/14/24 and a discharge date of 09/14/25 with diagnoses including quadriplegia, paralytic syndrome muscle weakness, contractures and tracheostomy.Review of Minimum Data Set (MDS) assessment dated [DATE] revealed no cognition score due to Resident #168 was rarely understood. Resident #168 was dependent on staff for toileting, bathing, personal hygiene, bed mobility and transfers.Review of care plan dated 07/27/25 revealed Resident #168 was at risk for falls related to immobility and paralytic syndrome. Interventions included assisting with all transfers and mobility and mechanical lift transfers with assistance of two staff members. Resident #168 had self-care deficits related to immobility, contractures, paralytic syndrome and quadriplegia. Interventions included mechanical lift transfers per order, providing total assistance with bathing, bed mobility, dressing and incontinence care. The care plan did not specify the number of staff required to safely provide assistance with bathing, bed mobility, dressing, or incontinence care.Review of Resident #168's care plan dated 07/27/25 revealed the resident had a communication problem related to aphasia and was able to shake his head up and down for yes and side to side for no. Interventions included to anticipate and meet needs, encourage non-verbal communication and monitor effectiveness of communication strategies by asking simple yes or no questions. The resident was at risk for pain with interventions including administer pain medication per physician orders, assess for pain, if experiencing pain rate pain using [NAME]-BAKER Faces Pain Scale, document/report complaints and non-verbal signs of pain.Review of a progress note dated 09/14/25 timed 7:12 P.M. authored by Licensed Practical Nurse (LPN) #397 revealed an aide had alerted her that Resident #168 had fallen during resident care. LPN #397 had observed Resident #168 in a sitting position on his buttocks and was on his knees with his head against the bed frame. Resident #168 was observed to have shearing to his right knee with no other injuries observed.Review of a progress note dated 09/14/25 time 7:40 P.M. authored by LPN #397 revealed Resident #168 was assessed from head to toe and due to Resident #168's contractures his range of motion was very limited. Resident #168 had shearing to the right knee with no other injuries observed. Resident #168 was noted to have had a pain level of 3-4 (out of 10) that was new after the fall. The note included the family and physician had been notified.Review of a progress note dated 09/14/25 timed 11:50 P.M. authored by Nurse Practitioner (NP) #511 revealed a call had been received as Resident #168's daughter had wanted Resident #168 to be sent to the hospital for evaluation related to fall that had occurred earlier. Resident #168 was unable to express pain, and she was concerned after he had hit the ground hard. NP #168 ordered Resident #168 to be sent to the hospital for evaluation per family request. Review of (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Resident #168's Medication Administration Record revealed on 09/14/25 at 7:52 P.M. the resident had a recorded pain level of four and was given Ibuprofen. The medical record contained no further follow up related to the resident's pain level. Review of a progress note dated 09/14/25 timed 11:55 P.M. authored by LPN #345 revealed Resident #168's daughter had called and insisted Resident #168 be sent to the hospital from a fall that had occurred at approximately 7:00 P.M. and was concerned Resident #168 had not been able to communicate pain.Review of a progress note dated 09/15/25 timed 9:08 A.M. authored by LPN #500 revealed Resident #168's fall had been reviewed by the interdisciplinary team. The charge nurse (name not identified) had been informed by Certified Nursing Assistant (CNA) (name not identified) that Resident #168 had rolled from bed during patient care. Upon entering Resident #168's room charge nurse observed Resident #168 in a sitting position , sitting on his feet, described as the position of a Muslims pray, facing the window with his head resting against the bed. Nursing assessment stated no injuries and no complaints of pain. Resident #168 was assisted back into bed by the assistance of three staff.Review of a fall investigation dated 09/14/25 revealed a statement authored by CNA #514 that during resident care on 09/14/25 at approximately 7:00 P.M. Resident #168 was placed on his right side and had rolled off the bed. Nurse and additional CNA had been notified for assistance and Resident #168 was assisted back into bed. CNA #464's statement had indicated she was unaware of the incident. The investigation did not identify the root cause of the fall or the level of assistance Resident #168 should have received. The investigation did not include if resident hit his head or not during the fall or evidence neurological checks were completed after the fall.Review of hospital paperwork dated 09/15/25 with a time of arrival of 1:07 A.M. revealed Resident #168 had presented to the emergency department following a four foot fall out of bed during resident care. Emergency Medical Services (EMS) reported the facility staff was initially hesitant to send Resident #168 to the hospital; however, family had requested transportation. Resident #168 had multiple fractures to his left pelvis and left hand. Resident #168 had obvious identified injuries that also included a hematoma to his left eyebrow, abrasions to his right knee and left ankles and toes. Resident #168's hospital paperwork had included no acute surgical interventions; however, Resident# 168 had remained hospitalized from [DATE] through 10/01/25.Interview on 02/24/26 at 8:53 A.M. with Registered Nurse (RN) #406 revealed he had cared for Resident #168 on several occasions prior to his discharge and stated Resident #168 required staff assistance from two (staff) for all care because he was a quadriplegic and was dependent (on staff) for care. RN #406 stated Resident #168 had multiple contractures of his upper and lower extremities and was unable to move himself.Telephone interview on 02/24/26 at 9:16 A.M. with LPN #397 revealed CNA #514 had alerted her that during resident care on 09/14/25 at approximately 7:00 P.M. Resident #168 had rolled out of bed and had fallen on the floor. LPN #397 stated CNA #514 had reported he had lost his grip on Resident #168 during care. LPN #397 stated upon entering Resident #168's room she had observed Resident #168 on the floor in a fetal position on his side and his head was against his feeding tube pole. LPN #397 stated she had observed Resident #168's right knee was reddened, and no other injuries were observed. LPN #397 stated Resident #168 was nonverbal, was dependent with care and required two staff members for care. LPN #397 stated due to Resident #168 being nonverbal he was unable to state pain and she stated she had mediated Resident #168 for pain because he fell. LPN #397 stated she had contacted Resident #168's family and physician and stated x-rays had been ordered; however, the x-rays had not been completed because Resident #168's family had called the facility toward the end of her shift at approximately 11:00 P.M. and had requested Resident #168 be sent to the hospital. LPN #397 stated the oncoming nurse had contacted EMS and Resident #168 had been transported to the hospital after she had left the facility. Telephone interview on 02/24/26 at 9:42 A.M. with CNA #464 revealed she had not witnessed Resident #168's fall on 09/14/25, however she had been made aware CNA #514 had been providing care by himself and Resident #168 had rolled out of bed and fallen on the floor. CNA #514 stated Resident #168 was dependent for all care and was an assist of two staff members for all care. CNA 464 stated she had entered Resident #168's room (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	and had observed Resident #168 in a fetal position on his side on the floor and was wedged between the floor and the nightstand. CNA #464 stated she had observed blood around Resident #168's mouth. CNA #464 stated she had assisted with placing Resident #168 back into bed and he was sent to the hospital a few hours later. Interview on 02/24/26 at 10:35 A.M. with the Director of Nursing (DON) revealed she had received a call from the facility on 09/14/25 (couldn't recall time or staff who had called) and was made aware of Resident #168's fall. The DON stated she had been informed CNA #514 had been providing Resident #168 with care unassisted (by another staff member) and Resident #168 had rolled out of bed and fallen on the floor. The DON stated she had not been made aware of any injuries and stated LPN #500 had completed the fall investigation, and she had reviewed Resident #168's medical records and his care plan had not indicated Resident #168 had required the use of two staff members; however, his care plan had included he was a total care. The DON stated Resident #168 had not returned to the facility after his hospital admission and stated she had not been provided with his hospital paperwork related to his fall.Review of the facility policy titled, Falls - Clinical Protocol, dated 01/06/25, revealed as part of the initial assessment the facility would attempt to identify individuals with a history of falls and risk factors for subsequent falling. For an individual who had fallen, staff would attempt to define possible causes. Based on the preceding assessment, the staff and physician would identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. 2. Review of Resident #162's medical records revealed an admission date of 05/30/25 with diagnoses including vascular dementia, alcohol abuse, difficulty walking and lack of coordination.Review of the MDS assessment dated [DATE] revealed Resident #162 had impaired cognition. Resident #162 required supervision with ambulation and bed mobility.Review of care plan dated 10/23/25 revealed Resident #162 was at risk for falls. Interventions included assist with all transfers, and mobility. Resident #162 had impaired cognition. Interventions included encourage resident to make routine and daily decisions. Care plan had not included wandering or elopement concerns or interventions.Review of elopement assessment dated [DATE] revealed Resident #162 was at low risk for elopement.Review of physician orders for December 2025 through February 2026 revealed no order for leave of absences.Review of progress note dated 12/22/25 timed 7:48 P.M. authored by Registered Nurse (RN) #468 revealed while on a leave of absence (LOA) Resident #162 had sustained a fall and EMS/police had transported resident to the hospital for evaluation.Review of hospital paperwork dated 12/22/25 with a time of arrival of 7:49 P.M. revealed Resident #162 had presented to the emergency department after she had escaped from the facility and was wandering outside looking for her husband and had sustained a fall. Resident #162 had tripped on a curb falling to the ground and struck her head. Resident #162 had a skin tear to her right elbow and superficial lacerations to multiple digits of her right hand.Review of email dated 12/23/25 timed 2:26 P.M. authored by Administrator regarding unauthorized LOA sent to the Department of Health revealed on 12/23/25 (date was incorrect) at around 6:00 P.M. Resident #162 was going to see her husband and while out she allegedly lost he balance and fell and was taken to the emergency department. Resident #162 was admitted to the hospital to rule out a urinary tract infection and Resident #162's had met resident at the hospital.Review of progress note dated 12/27/25 timed 12:54 P.M. authored by Nurse Practitioner (NP) #510 revealed Resident #162 had presented to the emergency department following a fall while she was wandering outside the facility looking for her husband and had fallen on a curb and stuck her head and aide had reported she had drank with her husband before. Resident #162 had been asked about her blood alcohol level and denied doing anything wrong, however she did wander off and knew she was not supposed to.Interview on 02/19/26 at 12:10 P.M. with Resident #162 revealed resident was confused and unable to recall incident on 12/22/25. Interview on 02/23/26 at 12:00 P.M. with NP #510 revealed Resident #162 was confused and had poor insight and judgement. NP #510 stated she had reviewed Resident #162's medical records and had observed an after visit summary (AVS) that had stated Resident #162 had been brought to the ED following a fall while she was outside. NP #510 stated she (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	could not recall specific information and had used the AVS when she had authored her progress note on 12/27/25. Interview on 02/23/26 at 12:46 P.M. with Licensed Practical Nurse (LPN) #435 revealed Resident #162 was confused and unable to make her own decisions. LPN #435 stated if residents had left the facility they were supposed to sign out at the receptionist desk and she was unaware if physician orders were to be in place for residents to have LOA privileges. LPN #435 stated Resident #162's husband had taken Resident #162 on LOA's after the incident and she had returned severely intoxicated.Interview on 02/23/26 at 2:15 P.M. with Director of Nursing (DON) revealed she had received a call from the facility on 12/22/25 (couldn't recall from who or a time) that stated Resident #162 was outside and had fallen and was taken to the ED for evaluation. DON stated she had not been made aware of where Resident #162 was located when the fall occurred. DON stated the Administrator had sent the email to ODH to inform of an unauthorized LOA. DON confirmed Resident #162 had impaired cognition as her BIMS score was an 11 at the time of the incident and no physician orders had been in place regarding residents ability to have LOA privileges. Interview on 02/24/26 at 11:08 A.M. with LPN #304 revealed she was Resident #162's assigned nurse on 12/22/25 and stated she had seen the resident sometime around 2:00 P.M. when she administered her afternoon medications. LPN #304 stated she had been unaware Resident #162 had left the facility until she had received a phone call from the supervisor that Resident #162 had been taken to the hospital (couldn't recall time). Telephone interview on 02/24/26 at 12:27 P.M. with RN #468 revealed he had received a phone call from the receptionist at approximately 7:00-7:15 P.M. on 12/22/25 that stated the police were on the phone and needed to speak with him. RN #468 stated a female police officer had stated they had found Resident #162 leaving a store and she had fallen and was being transported to the hospital. RN #468 stated he had not asked the police officer where or when the resident had been found. RN #468 stated he had not been aware Resident #162 had left the facility.Telephone interview on 02/24/26 at 12:55 P.M. with Receptionist #414 revealed she had arrived at the facility at approximately 2:30 P.M. on 12/22/25 and had seen Resident #162 shortly after she had arrived. Receptionist #414 stated she had not recalled seeing Resident #162 after that time or any visitors for her. Receptionist #414 stated she had received a call that evening (unable to recall time) from a police officer that stated Resident #162 was at the police station. Receptionist #414 stated she had transferred the call to RN #468.Interview on 02/25/26 at 1:45 P.M. with Administrator revealed he could not recall where he had gotten the time of the incident of 6:00 P.M. that was included in the email sent to ODH. Administrator further stated he was unaware of where he had received the information Resident #162 had been admitted to the hospital to rule out a urinary tract infection and the husband had met Resident #162 at the hospital. Administrator further stated he was unaware of where Resident #162 had been located.Review of facility policy titled Release of Responsibility for Leave of Absence revised 04/28/25 revealed residents who are their own responsible party may leave the facility for a leave of absence, residents are asked to inform their nurse when leaving the building. Residents who are not their own responsible party may leave the facility with a responsible party who may sign them out at the front receptionist desk.This deficiency represents non-compliance investigated under Complaint Number 2623301.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure timely incontinence care was provided to Resident #64 and adequate catheter care was provided to Resident #153. This affected one resident (Resident #64) of three observed for incontinence care and one resident (Resident #153) of two observed for catheter care. The facility census was 164.Findings include:1.Review of Resident #64's medical records revealed an admission date of 10/05/21. Diagnoses included muscle weakness, lack of coordination and diabetes.Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #64 had intact cognition. Resident #64 was dependent with transfers, non ambulatory and required max assistance with bed mobility and was incontinent of bowel and bladder.Review of care plan dated 12/22/25 revealed Resident #64 had self care deficits related to lack of coordination and was dependent with toileting. Interventions included staff to assist with completion of activities of daily living (ADL) care on a daily basis. Resident #64 was incontinent of bowel and bladder. Interventions included check resident for incontinence, offer to assist with toileting and if incontinent remove wet or soiled clothes and provide incontinence care.Interview on 02/19/26 at 1:59 P.M. with Resident #64 revealed he was incontinent of urine and had asked to be changed and had not been changed since the previous evening. Resident #64 stated he had recently asked the aide to change him, however the aide stated she was going on a break and would provide him with incontinence care when she returned. Observation revealed Resident #64 had a strong urine odor detected during interview.Interview on 02/19/26 at 2:20 P.M. with Certified Nursing Assistant (CNA) #303 revealed Resident #64 had requested incontinence care prior to her break and she had informed him she would change him when she returned. Observation of incontinence care following interview revealed Resident #64 was heavily soiled with urine that had soaked through his brief, through his clothing and onto his wheelchair. CNA #303 stated she had not provided Resident #64 with incontinence care during her shift and stated she was unaware he required incontinence care until he had informed her a short time prior.2.Review of Resident #153's medical records revealed an admission date of 01/30/26. Diagnoses included urinary retention, stroke with right sided weakness, and muscle weakness.Review of care plan dated 02/01/26 revealed Resident #153 was at risk for infection related to use of urinary catheter. Interventions included foley catheter care every shift.Review of MDS dated [DATE] revealed Resident #153 had intact cognition. Resident #153 was dependent with toileting and had indwelling urinary catheter.Review of current physician orders for February 2026 revealed to provide catheter care every shift and as needed.Observation on 02/26/26 at 11:38 A.M. revealed Resident #153 was calling out for assistance. Upon entering Resident #153's room, resident stated he was upset and stated he was laying in a dirty diaper.Interview on 02/26/26 at 11:48 A.M. with CNA #409 revealed he had provided Resident #153 with incontinence care approximately an hour before and was unaware Resident #153 required additional incontinence care. CNA #409 had proceeded to provide Resident #153 with incontinence care due to resident was incontinent of stool. Further observation revealed Resident #153's urinary catheter had a large amount of brown dried debris around the tubing. CNA #409 stated he had not provided Resident #153 with catheter care during his previous incontinence care and stated he was unsure when catheter care had last been provided.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, record review, and facility policy, the facility failed to ensure the menu was followed. This had the potential to affect 160 out of 164 residents who ate meals in the facility's kitchen, as four residents (Residents #7, #89, #123, and #146) received enteral nutrition and did not receive meals from the kitchen. The facility census was 164. Findings include:1.Review of the lunch menu for 02/19/26 revealed the residents were to receive braised beef tips, rice pilaf, buttered carrots, dinner roll and strawberry pretzel dessert. Observation on 02/19/26 from 11:35 A.M. to 1:00 P.M. of lunch tray line revealed dietary staff prepared the lunch meal that consisted of beef stew with rice, carrots, pears, dinner roll and ice cream. Interview with DM #426 at the time of observation revealed she substituted the beef tips for beef stew and added the rice to the beef stew due to resident preferences. DM #426 revealed she had to substitute the strawberry pretzel dessert due to the high cost of the dessert. Interview on 02/19/26 at 3:11 P.M. with Resident #134 revealed the food is so/so, was often cold, and the menu was often not followed.2. Review of dinner menu for 02/19/26 revealed the residents were to receive bratwurst patty on bun.Observation on 02/19/26 at 5:00 P.M. of dinner tray line revealed bratwurst was substituted for a turkey burger. Interview with DM #426 at the time of observation revealed the facility policy did not allow hot dog shaped bratwurst because it was a choking hazard and she was not able to order a non-hot dog shaped bratwurst. 3. Review of dinner menu for 02/25/26 revealed the residents were to receive confetti cake bar for dessert. Review of the spreadsheet menu for dinner revealed that residents on a pureed diet were to receive pureed confetti cake bar.Observation on 02/25/26 at 4:25 P.M. of dinner tray line revealed DM #426 had not pureed the confetti cake. Interview with DM #426 revealed the cake had not been pureed, she was unsure if they had enough and had planned on giving the pureed diets a different dessert. DM #426 revealed she would puree the confetti cake. Confirmed with Dietician #492 and Regional Director of Food Services #512 that residents on a pureed diet should be receiving the same food being served as the regular diet.Review of a policy titled, Dining and Meal Service, not dated, revealed Individuals will be provided with nourishing, palatable, attractive meals and will support each individual's daily nutritional and special dietary needs.This deficiency represents non-compliance investigated under Complaint Number 2638551 and 2745381.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, record review, and facility policy, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner. This had the potential to affect 160 out of 164 residents who ate meals in the facility's kitchen as four residents (Residents (#7, #89, #123, and #146) received enteral nutrition and did not receive meals from the kitchen. The facility census was 164. Findings include: 1.Observation and interview on 02/19/26 at 10:20 A.M. through 10:40 A.M. of the kitchen with Dietary Manager (DM) #426 revealed the following:-The fridge across from the stove was dirty with various food debris, splatter and dirt along bottom; black residue along back fridge wall, the walk-in fridge had dust on the two fans and dust on the ceiling that had blown from the fans, a container with lemonade that was not dated, a bag of expired arugula, four moldy cucumbers, a staff lunch box and energy drink can. Interview with DM #426 revealed they do not typically keep staff's food in the fridge.-The kitchen floor was extremely sticky and slippery. Large spots of dried black debris build-up. Pieces of yellow tape and other trash near the stove and tray line.-A panel in the freezer was falling off. DM #426 revealed she put in a work order but it was not fixed.-The dishwasher had a large accumulation of water on the ground. DM #426 revealed it was not leaking and that some water drips on the floor from the machine. Water was observed on the floor from the dishwasher to the ice machine approximately 2 feet away.-The wall behind the dishwasher and the wall behind the 3-part sink had pink tile that was extremely dirty with dust and dirt.-The ceiling tiles were extremely dirty with brown and black spots throughout. DM #426 revealed they had not been wiped down since she started 6 months ago.2. Observation and interviews on 02/19/26 at 11:35 A.M. to 1:12 P.M. of lunch tray line revealed the following observations that were confirmed with DM #426 and MS #335:-The vent in-between fridge and freezer of large amounts of black dust between where the ceiling tiles and the wall converge. Confirmed observation with Maintenance Supervisor (MS) #355.-Dust stands hanging from ceiling tiles and large amounts of black dust build up on ceiling tile grids. MS #335 revealed he had ordered new ceiling tiles and some were not up to code due to them being acoustic ceiling tiles. He did not have a receipt for the ceiling tile order.-The floor underneath the prep table had large amounts of built-up dust that was wet and matted on the floor.-Steal shelf holding food steel containers was dirty and had clean containers placed on top.-Dust build up behind the ice machine and on pipes, wires and ceiling. -Splatter on multiple lights in the kitchen.-The trash cans did not have lids.-The window by the freezer and stove was dirty and had staff clothing items, bags and a water bottle.-The warming oven was extremely dirty and had not been wiped down.-Tray carts had visible dried liquid spills and food debris. DM #426 said they are supposed to get wiped down daily but they do not get deep cleaned everyday.3. Observation and interview on 02/19/26 at 1:05 P.M. of lunch on 4th floor revealed the dining room tables had visible debris and liquid stains. Touching the table tops revealed they felt dirty with left over residue on them. Confirmed observation with Assistant Director of Nursing (ADON) #442 who said she was going to wipe down the tables and then never did.Observation and interview on 02/19/26 at 4:00 P.M. of kitchen with DM #426:-Convection steamer bottom compartment door did not close.-Two light bulbs were out in the stove hood.Review of facility policy titled General Sanitation of Kitchen with no date revealed, Food and nutrition services staff will maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule.This deficiency represents non-compliance investigated under Complaint Number 2745381.

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. Based on record review, observations, interviews and facility policy the facility failed to implement safe smoking policies and procedures. This had the potential affect all 37 smokers at the facility. The facility census was 164.Findings include:1.Review of the medical record for Resident #104 revealed an admission date of 06/29/09. Diagnoses included hypertensive heart and chronic kidney disease, type 2 diabetes, end stage renal disease, atrial fibrillation, dependence on renal dialysis, vascular dementia, post-traumatic stress disorder, anxiety, nicotine dependence.Review of the Significant Change in Status Minimum Data Set (MDS) assessment, dated 12/17/25, revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident had intact cognition. Review of the Plan of Care dated 12/26/25 revealed the resident had the potential for tobacco use related injuries or infection control issues related to smoking. Interventions included if resident was non-complaint with smoking policy, review smoking facility smoking policy and document education. Make sure the family is aware they are not to give cigarettes and/or lighters directly to the resident, but rather stored at the nurse's station.Record review for Resident #104 revealed a nursing note dated 02/22/26 at 6:02 A.M. of resident drinking vodka and smoking in her room. A nursing note dated 02/22/26 at 1:41 P.M. revealed nurse was notified that resident had a lighter in her room. Resident #104 gave lighter to nurse who provided education about facilities smoking policy. Further review revealed a social services note dated 02/23/26 of Licensed Social Worker (LSW) # 305 who provided education to resident about facilities smoking policy.Review of Resident #104 Smoking Evaluation dated 02/23/26 revealed resident smoked in designated smoking areas only, cannot safely use a lighter, can safely hold smoking materials, demonstrated compliance with facility smoking rules and was a supervised smoker.2. Observation on 02/19/26 at 8:49 A.M. revealed Resident #4 had a pack of cigarettes and a lighter in his room on a bedside table, not in a lockbox. Resident #4 was not present during observation. Observation further revealed an oxygen concentrator that was running in Resident #4's room. 3. Interview on 02/19/26 at 1:24 P.M. with Certified Nursing Assistant (CNA) #334 revealed she had been aware Resident #93 had been smoking in his room while his previous roommate, Resident #175 was in the room and had been wearing oxygen. CNA #334 stated Resident #175's family and also staff had complained about the smoking. CNA #334 stated Resident #175 was at the hospital and stated she was unsure if he would be returning and Resident #93 had been moved to another unit. Interview on 02/19/26 at 2:11 P.M. with Resident #93 revealed he was a smoker, however he denied he had smoked in his room. Interview on 02/23/26 at 10:40 A.M. with CNA #330 revealed she had been aware Resident #93 had smoked in his previous room while Resident #175 was present. 4. Observation on 02/19/26 at 2:33 P.M. revealed Resident #21 had been returning to his room and had a lighter on his bedside table not in a lock box. Interview with Resident #21 revealed he was a smoker and the lighter had belonged to him.5. Observation on 02/19/26 at 2:40 P.M. revealed Resident #105 was in the hallway in his wheelchair and had a pack of cigarettes in his shirt pocket and clothing had multiple burn holes. Interview with Resident #105 revealed he had cigarettes and a lighter on him and stated good luck taking them.Observation and interview on 02/19/26 at 2:48 P.M. of Resident #105 in his room revealed a smoked cigarette on the ground. Resident said it had fallen out of his pocket. Resident #105 had multiple burn holes on his shirt and jacket. Resident said he got them from putting out his cigarettes. The observation was confirmed at 3:36 P.M. through interview with Licensed Practical Nurse (LPN) #501.6. Interview and observation on 02/19/26 at 3:11 P.M. of Resident #134 in her room revealed the resident had cigarettes and lighter at bedside not in a lockbox. Resident #134 revealed she was unable to get to the outside smoking area due to the sidewalk being messed up. Observation and interview on 02/19/26 at 5:10 P.M. with Director of Nursing (DON) of outside smoking area revealed the sidewalk leading up to the smoking area had holes, cracks and was uneven. The smoking area was littered with various trash, cigarettes, an empty blood vial, three metal bars on the ground and the outside door was rusted at the bottom.7. Observation on 02/23/26 at 9:51 (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A.M. revealed Resident #4 had a lighter on his bedside table, not in a lockbox, while his oxygen concentrator was running and Resident #4 was sleeping. 8. Observation on 02/23/26 at 11:34 A.M. revealed two lighters on the floor in Resident #100's room not in a lockbox. Resident #100 was not present at time of observation and CNA #336 had confirmed the lighters and stated residents were not to have smoking materials kept in their rooms. Observation on 02/23/26 at 1:50 P.M. revealed oxygen in Resident #105's room across the hall from Resident #100's room. Observation of oxygen in Resident #105's room was confirmed by Registered Nurse (RN) #442.Interview on 02/23/26 at 2:14 P.M. with the DON revealed quarterly smoking assessments are completed for residents and as needed if there is a change in condition. If residents were independent they were able to keep their cigarettes in their rooms in a locked box. DON said facility will confiscate any smoking materials if residents are caught in the room smoking and provide education. 9. Observation on 02/24/26 at 11:13 A.M. on 4 [NAME] nursing station revealed smoking paraphernalia that had been smoked was placed on a vitals machine. Interview with Registered Nurse #406 confirmed the observation and placed the smoking paraphernalia in a plastic zipped bag which was given to the DON.10. Observation and interview on 02/26/26 at 11:32 A.M. of Resident #65 in his room revealed a pack of cigarettes on the ground next to him not in a lockbox. Resident said he had just dropped the pack on the ground. The observation was confirmed with Activities Staff #472 and Resident #65 told her he was saving the two half smoked cigarettes in the pack but he did not have a lighter in his room. Activities Staff #472 told resident she would get him a lockbox to keep his smoking material in because he was an independent smoker. 11. Observation and interview on 02/26/26 at 11:40 A.M. of Resident #27 revealed he was sitting on his bed with a pack of cigarettes. When asked if resident keeps his cigarettes in a locked box resident said he keeps them in his trash and no one is taking his cigarettes. Resident #27 placed cigarette pack under pillow and put some cigarettes under his sheets. The observation was confirmed with Licensed Practical Nurse (LPN) #320 who then tried to get the cigarettes from the resident who then yelled at surveyor to leave me the [expletive] alone and refused to give LPN #320 his cigarettes. The DON was informed Resident #27 had cigarettes in his room and was refusing to give them to the nurse. 12. Interview and observation on 2/26/26 at 1:57 P.M. with Receptionist #318 of residents cigarettes at the front desk revealed Receptionist #318 kept the supervised smoking residents smoking items at the front desk and that free will smokers kept their smoking items in a locked box in their rooms or at the nurses stations. Receptionist #318 revealed sometimes residents go to the store or families bring in cigarettes and lighters without their knowledge and the facility does do room sweeps. Observation on 02/26/26 at 2:40 P.M. revealed Resident #103 smoking in front of the facility and not in the designated smoking area in the back of the facility. Confirmed observation with DON who told Resident #103 that he had to smoke in the designated smoking areas. Review of list of smokers at the facility revealed 37 current residents that were smokers.Review of facilities policy titled Resident Smoking with a reviewed date of 01/06/25 revealed the facility has designated smoking times and areas; smoking materials including cigarettes, cigars, pipes, lighters, vapes, E-cigarettes must be locked up when not in use; smoking materials will only be used by the resident personally during smoking times, if it is determined by the interdisciplinary team that the resident can safely smoke independent of observation and assistance; smoking materials will be returned to the nurse's station or locked box; for those residents determined by the interdisciplinary team to require supervision and/or assistance with smoking, smoking materials will be monitored and dispensed by nursing staff, during designated smoking times only, and will not be given to the resident personally; and smoking aprons will be provided by the facility and will be worn by those residents determined to require them by the interdisciplinary team.This deficiency represents non-compliance investigated under Complaint Number 2745381.