STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365412	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Skilled Healthcare	1320 Mahoning Ave NW Warren, OH 44483

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, review of an Emergency Medical Services (EMS) Run Report, review of the American Heart Association (AHA) 2025 guidance for adult Cardiopulmonary Resuscitation (CPR), review of the facility CPR policy and interview, the facility failed to promptly and correctly provide basic life support (BLS) including Cardio-Pulmonary Resuscitation (CPR) to Resident #92, (a resident with advance directives for a Full Code status), when the resident was found unresponsive and absent of vital signs. This resulted in Immediate Jeopardy and actual serious life-threatening harm and subsequent death of Resident #92 on 03/07/26 at approximately 9:00 A.M. when Transportation Aide (TA) #873 identified Resident #92 was unresponsive. TA #873 alerted Licensed Practical Nurse (LPN) #915 Resident #92 was not responding/needed help and LPN #915 refused to help stating that's not my resident and told TA #873 to go get Registered Nurse (RN) #815. Instead of providing immediate care, RN #815 stated to TA #873 I'll get to it when I can. TA #873 then utilized the facility overhead paging system to summon assistance. LPN #824 responded from another unit and initiated CPR (chest compressions) after a five to 10 minutes delay; however, at no time were artificial respirations provided to Resident #92. When Emergency Medical Services (EMS) arrived at 9:24 A.M., Resident #92 was absent from pulse/respiration and was transported to the hospital emergency room with unchanged presentation arriving at 9:48 A.M. and declared deceased in the hospital emergency room on [DATE] at 9:50 A.M. This affected one resident (#92) of two residents reviewed for death. The facility census was 83.On 04/09/26 at 3:58 P.M. the Administrator, the [NAME] President of Nursing (VPN) #802, Director of Nursing (DON) #801, and the Assistant Director of Nursing (ADON) #803 were notified Immediate Jeopardy began on 03/07/26 at approximately 9:00 A.M. when facility staff failed to respond to and provide timely and adequate basic life saving measures/CPR to Resident #92 per the resident's advance directive. EMTs arrived and took over CPR and transported the resident to the hospital where he was pronounced deceased on [DATE]. The Immediate Jeopardy was removed on 04/10/26 when the facility implemented the following corrective actions:On 04/09/26 the facility (Administrator, Director of Nursing (DON) #801, and [NAME] President of Nursing (VPN) #802) initiated an internal investigation. As a result of the investigation corrective actions were put into place to ensure resident safety and prevent further risk related to delayed emergency response and CPR. On 04/09/26 at 5:30 P.M. DON #801 and VPN #802 completed a review of all CPR events within the past six (6) months were reviewed. On 04/09/26 a full house audit of 81/81 residents (to include 80 in house residents and one on a leave of absence) code status to include validation of code status, code status order, and signed documents, and advance directive care plans was initiated. All were validated by DON #801, and Assistant Director of Nursing (ADON) #803, to ensure accuracy and accessibility of code status. On 04/09/26 ADON #803 placed laminated signage on all crash carts identifying the location of the automatic external defibrillator (AED). The facility has three (3) crash carts located on unit one, unit three, and unit four. On 04/09/26 VPN #802 developed a Medical Emergency Response Policy addressing timely response and notification of licensed nursing staff during a change of condition or unresponsive episode. On 04/09/26 at 7:15 P.M. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a root cause analysis was completed by DON #801, VPN #802, ADON #803 and the Administrator. On 04/09/26 from 7:15 A.M. until 7:32 P.M. an Ad hoc Quality Assurance Performance Improvement (QAPI) meeting was held to review the root cause analysis (RCA) and the abatement plan. The meeting included DON #801, VPN #802, ADON #803, the Administrator, and the Medial Director via phone. The Ad Hoc QAPI reviewed the abatement plan to remove immediacy of jeopardy to include an implementation of a new policy to specify unlicensed staff role in alerting licensed personnel and timely response, review of prior CPR events in the past six months, education on high quality and CPR response with all licensed nursing staff, and implementation of mock code drills, The medical director was informed and updated on the facility plan. The QAPI committee accepted the plan and would continue oversight monitoring Beginning on 04/09/26 at 4:30 P.M. and continuing through 04/10/26 at 3:20 P.M. DON #801 provided education (verbally in person) to licensed nursing staff (20/21 LPNs, 5/6 RNs, 2/2 nurse practitioners), including the nurses who were involved in the CPR care on 03/07/2. Education topics included immediate CPR response, Code Blue activation, high-quality CPR (30:2 ratio), Ambu bag use and the new Medical Emergency Response policy. 1/21 LPNs and 1/6 RNs were educated verbally via phone and would sign in person prior to their next working shift. Beginning on 04/09/26 at 4:30 P.M. and continuing through 04/10/25 at 3:20 P.M. ADON #803, LPN #805 LPN #806 and Physical Therapy Assistant (PTA) #807 provided (verbally in person) education to non-licensed staff (29/37 Certified Nursing Assistants), 2/2 transportation Aides, 1/3 activities staff, 7/7 administrative staff, 13/13 food service staff, 15/15 environmental/maintenance staff, 4/7 therapy staff) on recognition of an unresponsive resident and the requirement to immediately notify nursing staff, clearly stating this is an emergency and the resident's location , to include the new Medical Emergency Response policy. 8/37 CNAs, 2/3 activity staff, 3/7 therapy staff were educated verbally via phone and would sign in-person prior to their next working shift. Beginning on 04/09/26 the facility implemented a plan for general orientation to include education on the facility Medical Emergency Response Policy and CPR policy. All newly hired staff would be educated by DON #801 or ADON #803 prior to assuming independent resident care responsibilities. On 04/10/26 at 2:00 P.M. Human Resources (HR) #804 completed an audit of licensed nurses (21 LPNs, six RNs, and two NPs) for current CPR certifications. Beginning on 04/13/26 the facility implemented a plan to host CPR mock code drills for licensed nurses led by certified CPR instructors Respiratory Therapist (RT) #808 and RT #809. These drills would be conducted on first, second, and third shift on 04/13/26 and on first and second shift on 04/14/26. Any licensed nursing staff who had not participated in a mock code drill by 04/14/26, would complete a drill with DON #801, RT #809 or ADON #803 prior to their next scheduled shift. The facility implemented a plan for the DON/designee to conduct mock code drills twice weekly for four (4) weeks, then monthly for two (2) months with emphasis on timely response and high-quality CPR. The facility implemented a plan for the DON/designee to complete an audit of all crash carts to validate inventory and CPR readiness; additionally, an audit would be conducted on all new admission/readmission to validate code status order, accuracy, and care plan weekly for four weeks, then monthly for two months. The facility implemented a plan for all CPR/emergency events to require DON lead investigations, reviewed by Regional VPN #810 evaluating timeliness of response and adherence to CPR standards. This review would be expected to be completed within 24 to 48 hours following any CPR event. All findings would be reviewed by the QAPI Committee. The QAPI committee would meet monthly and as needed. Although the Immediate Jeopardy was removed on 04/10/26 the deficiency remained at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance.Review of the closed medical record for Resident #92 revealed an admission date of 02/07/26 with diagnoses including atrial fibrillation, type two diabetes, congestive heart failure (CHF), end stage renal disease (ESRD), anxiety, dementia, left kidney cancer, anal fistula, hypertension and dependency on renal dialysis. Resident #92 was discharged from the facility on (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	03/07/26 and expired at the hospital on [DATE].Review of Resident #92's physician order dated 02/08/26 revealed the resident was a full code (all life-saving measures/interventions including but not limited to cardiopulmonary resuscitation (CPR)). The resident also had a physician order for oxygen (O2) at two liters per minute via nasal cannula as needed for shortness of breath and an order for (hemo)dialysis treatments at 10:15 A.M. at an outside dialysis center every Tuesday, Thursday, Saturday.Review of the care plan initiated 02/13/26 revealed Resident #92 was at risk for ineffective breathing related to diagnoses of CHF and ESRD. Interventions included check breath sounds and monitor/document for labored breathing, monitor/document for the use of accessory muscles while breathing, oxygen therapy as needed, vital signs as needed, give cardiac medications as ordered and monitor lab work.Review of Resident #92's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had slight cognitive impairment, was independent with eating, dependent on staff for toileting, required partial to moderate assistance from staff with showers and substantial to maximum staff assistance with bed mobility. Resident #92 used intermittent oxygen therapy per the assessment.Review of Emergency Medical Services (EMS) (Run Number 26-22237) report, dated 03/07/26, revealed a call was received (on 03/07/26) at 9:18 A.M. with arrival to the facility at 9:24 A.M. Resident #92 was found unresponsive with facility staff performing CPR. Staff reported witnessing resident arrest. Staff instructed to pause. Resident was pulseless and apneic (not breathing). The resident was in pulseless electrical activity (PEA) and administered three doses of epinephrine (a drug administered to help restart effective circulation and improve chances of getting a pulse back) and given calcium. The resident was intubated and transport initiated. A fourth and fifth dose of epinephrine were given with no change in presentation. Care was transferred to the hospital staff at the emergency room (ER). Arrival at ER 9:48 P.M.Review of a facility progress note dated 03/07/26 at 9:55 A.M. and authored by Registered Nurse (RN) #815 revealed called to resident room at 09:14 per transportation aide to check resident. Resident was lying in bed on back unresponsive to verbal, tactile stimuli or to sternal rub. Resident pupils minimally responsive. Blood pressure (BP) 83/38 (hypotensive), heart rate (HR) 27 (bradycardic) with no respirations noted; unable to obtain pulse ox (oxygen saturation level). Skin warm and clammy. No palpable auscultated pulse. Bed flattened, CPR initiated at 09:15. Non-rebreather mask applied at 15 L (liters) per portable O2 (oxygen) tank. At 09:17 bed board applied CPR continue. EMS called and informed that resident in full arrest. AED called for. At 09:18 AED applied shock advised then prompts followed to continue CPR. At 09:20 EMS on site, status report given. IO (intraosseous line to deliver fluids) placed left knee per ambulance personnel. Epi and calcium given per squad who also placed their AED. 09:23 CPR continues. 09:25.Review of a facility progress note dated 03/07/26 at 10:11 A.M. authored by RN #815 revealed 09:25 continued EMS states that there is a disorganized rhythm on AED with HR of 94 but no palpable pulse. CPR continued. At 09:30 squad left facility. At 09:33 report called to hospital. At 09:36 brother notified of change in status and to call facility. At 10:00 phone call received from hospital ER stating the resident expired at 09:50 A.M.Review of a late entry progress note dated 03/07/26 at 11:27 A.M. authored by RN #815 revealed resident last known well time was when aide delivered breakfast tray at 8:45 A.M. Resident was sleeping and aide told him his tray was at the bedside and he mumbled oh, ok.An interview on 04/08/26 at 1:44 P.M. with Registered Nurse (RN) #815 revealed she was the assigned nurse for Resident #92 on 03/07/26. RN #815 stated Transportation Aide (TA) #873 was seeing if Resident #92 was going to dialysis on 03/07/26 in the morning and saw something was wrong with him. RN #815 then stated TA #873 came to her and said she needed to go see Resident #92 because there was something wrong with him. RN #815 stated she told TA #873 I'll be there when I can and proceeded to assist another resident she was working with. RN #815 stated TA #873 then stated, I don't think it can wait, and again RN #815 stated she told her OK, I'll be there when I can. RN #815 stated there was a three-to-four-minute delay from the time she was told there was an issue with Resident #92 to when she went to his room. RN #815 stated when she entered Resident #92's room he needed CPR, so she started compressions. RN #815 stated she could not remember (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	who else was in the room and could not remember who called 911. An interview on 04/08/26 at 3:00 P.M. with ADON #803 revealed LPN #915 was working at the time of the incident. LPN #915 had stated that's not my resident, to Transportation Aide (TA) #873 when TA #873 first approached LPN #915 about Resident #92 needing help the morning of 03/07/26. ADON #803 confirmed LPN #915 did not help or assess the resident. ADON #803 revealed LPN #915 was terminated due to this incident/situation.Review of LPN #915's employee file revealed a hire date of 02/11/26 and a termination date of 03/19/26 for poor performance. There were no specific details in the termination documentation to illustrate the termination was related to LPN #915 refusing to provide nursing intervention to Resident #92 during a change of condition on 03/07/26.An interview on 04/08/26 at 3:10 P.M. with LPN #824 revealed she was working on the secured unit the morning of 03/07/26 and overheard a page requesting help in Resident #92's room because there was something wrong with him and no other nurse would go and assess him. LPN #824 stated when she entered the room no one else was in there and the resident was absent of vital signs. LPN #824 stated she began chest compression and yelled for help. LPN #824 stated RN #815 then entered the room with the crash cart and was attempting to insert an intravenous (IV) line. At this time no one was supporting the resident's respiration, as no one was supplying breaths via mouth or by Ambu bag. When asked if anyone was giving Resident #92 oxygen, LPN #824 stated no she did not believe anyone did. LPN #824 stated an AED was applied and a shock was advised and given and then EMTs arrived and took over the resident's care. LPN #824 stated Resident #92 was transported to the emergency room where he then expired.An interview on 04/09/26 at 10:00 A.M. with TA #873 revealed she was working on 03/07/26 and had gone into Resident #92's room and found the resident in distress. TA #873 revealed she immediately went and got LPN #915; however, LPN #915 would not come help Resident #92 stating LPN #915 said that's not my resident. LPN #915 also did not come in to help with CPR for Resident #92. TA #873 revealed she then went to RN #815 to try to get help for the resident and the RN stated, I'll get to it when I can. TA #873 told RN #815 it cannot wait, Resident #92 was in distress and again RN #815 stated I'll be there when I can. TA #873 stated that morning on 03/07/26 she had gone into the resident's room at approximately 9:00 A.M. to see if he was ready for dialysis and the resident was still in bed, he did not respond to her and just took a deep breath in and let it out and then was absent of respiratory effort. She stated she went over to the resident and tapped his leg and shouted his name with no response. She then went to the first nurse she saw who was LPN #915 who stated to her that is not my resident and told her to go get RN #815. She then went to RN #815 who also did not come to the resident's room. TA #873 stated she made an announcement over the PA system to get someone to come in and help. TA #873 stated LPN #824 came down from the secured unit to assist. TA #873 stated she was waiting outside Resident #92's room for approximately five to 10 minutes before anyone came to help Resident #92. RN #815 entered the room with the pulse oximeter and stated there was no heart rate and then said she needed to find out if the resident was full code or a Do Not Resuscitate (DNR). LPN #824 had entered and started chest compressions, but at no point did anyone provide artificial breaths to the resident with the use of an Ambu bag. TA #873 stated she was the one who called 911 and when they arrived, they stated to provide the resident with artificial respirations and took over CPR and transported the resident to the hospital.An interview on 04/09/26 at 10:48 A.M. with RN #815 verified no artificial respirations were provided to Resident #92 even though he was not breathing. She confirmed there was an Ambu bag available on the side of the crash cart. An interview on 04/09/26 at 11:15 A.M. with CNA #866 revealed on 03/07/26 she had taken Resident #92's breakfast tray to him between 8:15 A.M. and 8:30 A.M. and he was still in bed. CNA #866 revealed the resident replied Oh Ok when told his breakfast tray was there. CNA #866 stated the resident's breakfast tray remained untouched.An interview conducted on 04/09/26 at 1:30 P.M. with DON #801 revealed the facility did not do an internal investigation related to the CPR performed for Resident #92 at the time of the incident. The DON revealed it wasn't until the state surveyors started to question the quality and timeliness of the CPR (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	provided during the annual survey that the facility initiated an investigation.An interview on 04/09/26 at 1:52 P.M. with the Administrator revealed Resident #92 and one other resident (Resident #98) had required CPR in the past 6 months. The Administrator confirmed there had been no investigation completed into the incident and subsequent death of Resident #92, and Resident #98 had also not been reviewed until after the concerns were brought forth by the state surveyors for Resident #92 during the annual survey.An interview on 04/09/26 at 3:00 P.M. with LPN #833 revealed (on 03/07/26) she entered Resident #92's room and jumped in to help with chest compressions. She was alerted to a situation going on by over hearing TA #873 yelling for RN #815 and went down to see what was going on. She also stated she called 911 as well and instructed the CNAs to go get the AED. She stated she was not aware of LPN #915 initially refusing to go and help and of the statement made by him that that was not his resident. She also confirmed at no time were artificial respirations given to the resident while she was in the room.Review of the American Heart Association (AHA) 2025 guidance for adult CPR included the following: Check for breathing, if the person is not breathing or only gasping, begin CPR; Chest compressions included to push down hard and fast at a rate of 100 to 120 compressions per minute; After every 30 compressions, give two rescue breaths; and make sure the person is on a firm surface. In 2008, after the publication of several studies looking at the rates of bystander CPR and public attitudes toward it, the AHA updated their guidance and decided to take out rescue breathing (mouth to mouth) for untrained or lay responders as a way to encourage and focus on hands only CPR. This updated guidance did not apply to trained healthcare professionals. Review of the facility policy titled Cardiopulmonary Resuscitation (CPR) last revised 10/25/25 revealed it was the facility policy to adhere to residents' rights to formulate advanced directives. In accordance with these rights, this facility would implement guidelines regarding cardiopulmonary resuscitation (CPR).The facility would follow current American Heart Association (AHA) guidelines regarding CPR.If a resident experienced a cardiac arrest, facility staff would provide basic life support, including CPR, prior to the arrival of emergency medical services and:In accordance with the resident's advanced directives, [NAME] the absence of advanced directives or a Do Not Resuscitate order: andIf the resident does not show obvious signs of clinical death (e.g. rigor mortis, dependent lividity, decapitation, transection, or decomposition).CPR certified staff would be available at all times.Staff would maintain current CPR certification for healthcare providers through a CPR provider whose training includes a hands-on session either in a physical or virtual instructor-led setting I accordance with accepted national standards.This deficiency represents noncompliance investigated under Complaint Numbers 2977495.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review, the facility failed to take reasonable steps to ensure residents were assisted by a designated staff member for conducting resident council meetings and residents were timely informed of meetings in advance. This had the potential to affect all 83 residents residing in the facility. The facility census was 83. Findings include:Record review of the facility Activity Calanders dated January 2025, February 2025, March 2025, April 2025, October 2025, November 2025, December 2025, January 2026, February 2026, March 2026, and April 2026 revealed there were no resident council meetings identified on the calendars. There were no available activity calendars to review for May of 2025, June of 2025, July of 2025, August of 2025, and September of 2025.An interview on 04/08/26 at 10:40 A.M. with the Administrator revealed there were no resident council meetings held in February of 2026 and March of 2026 due to lack of a president for the meetings. The Administrator verified he had resident council meeting minutes for January 2026 only and handed the surveyor meeting minutes dated 01/28/26 that indicated five residents attended the meeting and staff attending included the Activity Director and the Director of Nursing. There was no future meeting date on the minutes. An interview on 04/09/26 at 10:10 A.M. with Activity Director (AD) #876 revealed she was not aware she needed to save activity calendars and otherwise had no evidence to show when resident council meetings were held for the aforementioned months in 2025 and 2026. AD #876 stated her and her staff go and get residents for council meetings when they are due to be held. AD #876 stated resident council meetings are held monthly, and a meeting was going to be held this week. On 04/13/26 at 10:30 A.M. a resident council meeting was held with surveyors as part of the annual survey. Residents #15, #38 and #11 were in attendance. Resident #11 stated there had not been resident council meetings in February and March of this year due to no president. Resident #11 further stated, We were supposed to have one last week but, it was canceled. Resident #11 stated she was informed it was canceled, as there was no one to run the meeting.

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give residents a notice of rights, rules, services and charges. Based on record review and staff and resident interviews, the facility failed to ensure residents were informed of their rights on an ongoing basis. This had the potential to affect all 83 residents currently residing in the facility.Findings include:On 04/08/26 at 10:40 A.M. an interview with the Administrator revealed there were no Resident Council meetings held in February of 2026 and March of 2026 due to lack of a president for the meetings. The Administrator handed the surveyor one month of council meeting minutes dated 01/28/26. Interview with the Administrator further revealed there was no evidence that Residents' Rights were discussed at the January 2026 Resident Council Meeting. Completion of the Resident Council portion of the annual survey on 04/13/26 between 10:30 A.M. and 10:52 A.M. with Residents #11, #15 and #38 revealed there was no ongoing review of Residents' Rights during the resident council meeting or in any other fashion at the facility.Review of the available Residents Council meeting minutes from January 2026 revealed no evidence that Residents' rights were reviewed during the resident council meeting. There were no additional Resident Council meeting minutes available for review.

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The resident has the right to receive notices in a format and a language he or she understands. Based on record review and staff and resident interviews, the facility failed to inform the residents of their right to file a complaint with the State survey and certification agency. This had the potential to affect all 83 Residents in the facility.Findings include:On 04/08/26 at 10:40 A.M. an interview with the Administrator revealed there were no Resident Council meetings held in February of 2026 and March of 2026 due to lack of a president for the meetings. The Administrator handed the surveyor one month of council meeting minutes dated 01/28/26. The interview with the Administrator further revealed there was no evidence that Residents' Rights to file a complaint with the State survey and certification agency were discussed at the January 2026 Resident Council Meeting. Completion of the Resident Council portion of the annual survey on 04/13/26 between 10:30 A.M. and 10:52 A.M. with Residents #11, #15 and #38 revealed there was no information shared or discussed regarding the residents' right to file a complaint with the State survey and certification agency. Residents #11, #15 and #38 also stated they had no knowledge about where the information was posted in the facility.Review of the available Residents Council meeting minutes from January 2026 revealed no evidence that Residents' rights were reviewed during the resident council meeting. There were no additional Resident Council meeting minutes available for review.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview, record review and facility policy review, the facility failed to ensure all residents were informed on the grievance filing process. This had the potential to affect all 83 residents residing in the facility. The facility census was 83. Findings include:Record review of the facility document titled Grievance Committee Handbook, undated, revealed three residents, a fourth person (status unidentified) and two staff comprised the grievance committee. A note indicated a representative from the Ombudsman program will also be invited. This handbook was located on the bulletin board outside of the activity room. The handbook indicated in the event a grievance was filed, the above members would be contacted by the licensed social worker for a grievance meeting.Review of the resident council minutes dated 01/28/26 revealed there was no information presented to the council on how to file a grievance. Review of the facility document titled Grievance Committee Roster, with a review date of April 2026, revealed the grievance committee membership consisted of the Administrator, the Director of Nursing, Social Service #883, Infection Preventionist #803, Food Service Director #892 and Business Office Manager #881. There were no residents listed as committee members. An interview on 04/08/26 at 3:00 P.M. with the Administrator verified the updated grievance committee roster lacked inclusion of resident committee members on the document. An interview on 04/14/26 at 10:30 A.M. with Residents #11, #15 and #38 as part of the annual survey resident council meeting with the state surveyor revealed Resident #11, Resident #15 and Resident #38 all stated they had no knowledge of a grievance committee, and all were unaware of how to file a grievance. Resident #11 stated there had been no resident council meetings in February or March 2026 and the grievance process was not discussed at resident council when meetings were held. An interview on 04/14/26 at 11:00 A.M. with the Administrator revealed he had no knowledge of the grievance committee handbook that was hanging outside of the activity room. The administrator further stated the information in the grievance committee handbook was outdated.Review of the facility policy titled Resident and Family Grievances dated 01/01/25 revealed it was the policy of the facility to support each resident's and family members' right to voice grievances without discrimination, reprisal, or fear of discrimination or reprisal. The policy further stated notices of residence rights regarding grievances will be posted in prominent locations throughout the facility. Finally, the policy stated information on how to file a grievance or complaint will be available to the resident. Information may include but is not limited to the contact information of the grievance official with whom the grievance can be filed, including his or her name, business address, and business phone number. The contact information of independent entities with whom grievances may be filed that is pertinent including the state agency, quality improvement organization, state survey agency, and state long term care ombudsman program or protection and advocacy system.

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Community Skilled Healthcare	1320 Mahoning Ave NW Warren, OH 44483

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. Based on review of records and interviews, the facility failed to ensure the activities program was directed by a qualified professional. This had the potential to affect all residents residing in the facility. The facility census was 83. Findings include:Review of the facility document titled Job Description of Activity Director revealed it was signed by AD #876 on 04/21/25 and witnessed by Human Resources (HR). The position reported directly to the Administrator. The professional qualifications included successfully completed the MEPAP 1 (a foundational accredited course designed to qualify participants for the Activity Professional Certified designation through the National Certification Council for Activity Professionals), ADC (activity director certified) or working on progress, and has at least one year of activity experience in long-term care. Review of the personnel file for Activity Director (AD) #876 revealed a date of hire as 09/09/2020 for the position of housekeeping. The file also contained a letter of resignation dated 08/23/21 from the position of activities. There were no job descriptions or payroll status changes in the record to indicate when AD #876 transferred to activities between 09/09/2020 to 08/23/21 or what department the employee may have changed to after 08/23/21. There was no evidence in the personnel file of AD #876 completing the professional qualifications required for the position of Activity Director as specified in the job description. On 04/08/26 at 10:45 A.M. an interview with AD #876 revealed she had been at the facility working for seven years in both housekeeping and activities. AD #876 stated she had started as activity director approximately 03/19/25. AD #876 stated she received her activity certification in March of 2026 but did not have proof of the certification to show the surveyor. AD #876 stated she was never trained for the position as the activity director because the former activity director told her she was not going to show her anything. On 04/09/26 at 11:00 A.M. a follow-up interview with AD #876 confirmed she signed the job description for the Activity Director position on 04/21/25. AD #876 stated she was never trained for the position of Activity Director and stated she had no idea what was required of the position. On 04/09/26 at 12:30 P.M. interview with the Administrator revealed he was unaware AD #876 worked in housekeeping prior to being the activity director. The Administrator stated AD #876 had approached him about the position, so the Administrator asked around about her to other staff then promoted her to Activity Director.On 04/09/26 at 1:38 P.M. interview with Human Resources Director (HRD) #804 revealed she could not verify the dates of when AD #876 went from housekeeping to the activity department between 09/09/2020 and 08/23/21 because there were no payroll changes or position changes in her employee file. HRD #804 stated she believed AD #804 went to housekeeping on 10/19/21 but could not verify the date with documentation. On 04/13/26 at 3:20 P.M. an interview with Human Resource Director (HRD) #804 verified the facility had no evidence AD #876 had successfully completed the required professional certifications to hold the position of activity director and verified the absence of certification in the personnel file for AD #876. HRD #804 further stated she had been asking for the certification from AD #876 for over a month.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, job description review and interview the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This had the potential to affect all residents who resided in the facility. The facility census was 83.Findings include:Review of the facility job description for Nursing Home Administrator revealed the Administrator signed the job description [DATE]. The document stated the nursing home administrator was responsible for the overall management, operation, and quality of care within a long-term care facility. This rule ensures compliance with all federal, state, and local regulations for maintaining a safe, supportive, and high-quality environment for residents, staff, and visitors. The administrator oversees clinical, financial, and operational functions and lead staff to deliver compassionate and efficient care. One of the key responsibilities listed was overseeing daily operations of the nursing home, including clinical services, staffing, and facility management. Further key responsibilities were stated as the licensed nursing home administrator will hire, train, and supervise and evaluate department heads and staff.Review of the facility job description for Director of Nursing revealed the director of nursing (DON) signed the job description on [DATE]. The document revealed that the director of nursing was responsible for the overall leadership, management, and direction of the nursing department within a nursing home or long-term care facility. This rule ensures the delivery of high-quality resident care in compliance with all regulatory standards while promoting a culture of compassion, safety, and clinical excellence. The director of nursing supervises nursing staff, coordinates care services, and collaborates with interdisciplinary teams to meet residents' medical and personal needs.Review of the Job Description of Activity Director revealed it was signed by Activity Director (AD) #876 on [DATE]. The document stated the activity director was a department head directly responsible for the planning, coordinating, supervising, and implementing a meaningful and ongoing activity program that fulfills the physical, social, mental, spiritual, and psychosocial well-being of all residents who choose to participate in a group setting, individually, or on a one-on-one basis. The program shall be in compliance with company policy, as well as with state and federal regulations. The activity director reports directly to the administrator. Professional qualifications included: successfully completed having at least one year activity experience in long term care, activity director certification (ADC) or working on process, MEPAP 1 (Modular Education Program for Activity Professionals 1), effective interpersonal and communication skills, and cardio pulmonary resuscitation preferred, but not required upon hire. Personal qualifications included must be dependable, flexible with work hours including evenings, holidays, and weekends, and possess a desire to learn and share. Essential functions included to keep the activity program in total compliance with all federal, state, and local laws and regulation and providing information and interacts with the survey team during the annual survey. Other essential functions within the job description included to supervise and delegate activity staff, participate in interdisciplinary team meetings, follow facility policy and procedures, maintain and promote all resident rights, train new personnel, and performs any related duties as specified by the administrator. Specific functions of the job were listed as planned outings in the community, inform, invite, and transport residents to and from activity area as needed, and assist resident with resident council meetings.During the annual and complaint survey, observations, record reviews and interviews resulted in concerns related to the overall operation of the facility including but not limited to resident council, residents rights conveyance, grievance processes, activities dedicated to the needs of all residents, qualifications of the activities director, quality of care, transfer agreements, a complete and thorough facility assessment to address all areas of the facility, and staff training. The facility failed to provide evidence administrative staff, including the Administrator, the DON and AD (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	#876 had effective systems in place to timely identify and correct quality, care and other concerns as follows:A. The facility did not ensure reasonable steps were taken to ensure residents were assisted by a designated staff member for conducting resident council meetings, and residents were informed in advance of resident council meetings. Record reviews of the available Activity Calanders dated for 2025 and 2026 revealed resident council meetings were not advertised on the calendars. An interview on [DATE] at 10:40 A.M. with the Administrator revealed there were no resident council meetings held in February of 2026 and March of 2026 due to lack of a president for the meetings. The Administrator verified he had resident council meeting minutes for [DATE] only and handed the surveyor meeting minutes dated [DATE] that indicated five residents attended the meeting and staff attending included the Activity Director and the Director of Nursing. There was no future meeting date on the minutes. On [DATE] at 10:30 A.M. a resident council meeting was held with surveyors as part of the annual survey. Residents #15, #38 and #11 were in attendance. Resident #11 stated there had not been resident council meetings in February and March of this year due to no president. Resident #11 further stated, We were supposed to have one last week but, it was canceled. Resident #11 stated she was informed it was canceled, as there was no one to run the meeting. (see F565).B.The facility did not ensure residents were informed of their rights on an ongoing basis, and did not ensure all residents were informed on how to file a complaint with the state agency and the grievance filing process. Review of the resident council minutes dated [DATE] revealed there was no information presented to the council on resident rights. On [DATE] at 10:40 A.M. an interview with the Administrator revealed there were no Resident Council meetings held in February of 2026 and March of 2026 due to lack of a president for the meetings. The Administrator handed the surveyor one month of council meeting minutes dated [DATE]. On [DATE] at 10:30 A.M. a Resident Council meeting was conducted with Residents #11, #15 and #38. All stated resident rights were not reviewed at resident council meetings. All stated they had no knowledge of a grievance committee. They also stated they were unaware of how to file a grievance, and no information was shared or discussed on how to file a complaint with the state agency. All stated they did not know where to find this information in the facility (see F572, F574, F585).C.The facility did not ensure licensed nursing staff promptly and correctly provided basic life support (BLS) including Cardio-Pulmonary Resuscitation (CPR) resulting in Immediate Jeopardy and actual serious life-threatening harm and subsequent death of Resident #92 on [DATE] at approximately 9:00 A.M. when Transportation Aide (TA) #873 identified Resident #92 was unresponsive. TA #873 alerted Licensed Practical Nurse (LPN) #915 Resident #92 was not responding/needed help and LPN #915 refused to help stating that's not my resident and told TA #873 to go get Registered Nurse (RN) #815. Instead of providing immediate care, RN #815 stated to TA #873 I'll get to it when I can. TA #873 then utilized the facility overhead paging system to summon assistance. LPN #824 responded from another unit and initiated CPR (chest compressions) after a five to 10 minutes delay; however, at no time were artificial respirations provided to Resident #92. When Emergency Medical Services (EMS) arrived at 9:24 A.M., Resident #92 was absent from pulse/respiration and was transported to the hospital emergency room with unchanged presentation arriving at 9:48 A.M. and declared deceased in the hospital emergency room on [DATE] at 9:50 A.M. The Immediate Jeopardy was removed on [DATE] when the facility implemented corrective actions. Although the Immediate Jeopardy was removed on [DATE] the deficiency remained at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. (see F678).D. The facility did not ensure residents received a program of therapeutic activities and one-to-one activities for their highest practicable well-being and did not ensure a qualified activity professional held the position of activity director. Review of the facility document titled Job Description of Activity Director revealed it was signed by AD #876 on [DATE] and witnessed by Human Resources (HR). The position reported directly to the Administrator. The professional qualifications included successfully completed the MEPAP 1 (a foundational accredited (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	course designed to qualify participants for the Activity Professional Certified designation through the National Certification Council for Activity Professionals), ADC (activity director certified) or working on progress, and has at least one year of activity experience in long-term care. Review of the personnel file for Activity Director (AD) #876 revealed there was no evidence in the personnel file of AD #876 completing the professional qualifications required for the position of Activity Director as specified in the job description. Observation was conducted on [DATE] between 5:50 P.M. to 6:20 P.M. on the secured memory care unit of the facility. Eight residents were observed lying in their beds. Five residents' rooms were noted with their doors closed so they were not disturbed during the observation period. There were 11 residents sitting in the dining room area not engaged in therapeutic visual, auditory, tactile or other sensory activities to occupy these residents. The observation further revealed that residents in the dining room were becoming increasingly restless and difficult to redirect while aides and nurses were tending to other residents' toileting needs after dinner. An interview with Licensed Practical Nurse (LPN) 807 during this observation revealed structured activities rarely happen on the unit especially at night after dinner. LPN #807 was unable to recall the last time an activity occurred on the memory care unit after dinner and stated there is no activity programming in general for the unit and she does not know why. An observation on [DATE] at 9:50 A.M. on the memory care unit revealed no structured, therapeutic activities were taking place on the memory care unit, and there were six residents sitting in the common area in front of a television.On [DATE] at 10:00 A.M. an interview with Registered Nurse (RN) #871 revealed there was no dedicated activity calendar for the dementia unit. RN #871 stated it was up to the nursing staff on the unit to do things for the residents, so the residents were going to have a movie at 3:00 P.M. that afternoon and she was the one who planned it and purchased the snacks for the activity. RN #871 further stated planned activities for the memory care unit are rare.On [DATE] at 10:45 A.M. an interview with AD #876 revealed she had been at the facility working for seven years in both housekeeping and activities. AD #876 stated she had started as activity director approximately [DATE]. AD #876 stated she received her activity certification in March of 2026 but did not have proof of the certification to show the surveyor. AD #876 stated she was never trained for the position as the activity director because the former activity director told her she was not going to show her anything. AD #876 also stated one-to-one visits were scheduled on the activity calendar at 6:00 P.M. and activity staff were scheduled to leave at 4:00 P.M. AD #876 stated on [DATE], for example, the one-to-one activity did not get done because staff left at 4:00 P.M. On [DATE] at 10:10 A.M. a follow up interview with AD #876 revealed she started her position as the AD in [DATE]. AD #876 stated she did not keep a record of activity calendars for the memory care unit and confirmed she had none to show from [DATE] through [DATE] of what activities were planned for the residents during that period on the memory care unit. On [DATE] at 11:00 A.M. an interview with AD #876 confirmed she signed the job description for the Activity Director position on [DATE]. AD #876 stated she was never trained for the position of Activity Director and stated she had no idea what was required of the position. On [DATE] at 9:50 A.M. an interview with Activity Assistant (AA) #878 revealed there were no dedicated activities for the memory care unit recently. AA #878 stated he felt it had been approximately two months since there were dedicated activities for the memory care unit. An observation of the memory care unit at the time of the interview revealed one resident (Resident #8) in the common area in a wheelchair with his head down on the table, two residents dozing in recliners in the common area, and two female residents coloring on coloring pages.On [DATE] at 3:20 P.M. an interview with Human Resource Director (HRD) #804 verified the facility had no evidence AD #876 had successfully completed the required professional certifications to hold the position of activity director and verified the absence of certification in the personnel file for AD #876. HRD #804 further stated she had been asking for the certification from AD #876 for over a month. An interview on [DATE] at 2:07 PM with AA #879 revealed the employee who was responsible for completing all one-on-one visits was no longer employed at the facility and had no knowledge if one-on-ones were being completed (see F679, (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	F680). E. The facility did not ensure a current transfer agreement with a local hospital. Review of the facility document titled Transfer Agreement, revealed the transfer agreement was by and between Community Skilled Healthcare Center located at 1320 Mahoning Ave. N.W. [NAME], Ohio 44483 and Mercy Health Youngstown LLC doing business as Saint [NAME] Hospital located at 667 [NAME], [NAME], Ohio 44482. The document further revealed the agreement shall take effect on the date signed by both parties and continue for two years unless terminated by either party within 30 days written notice to the other party. The document was signed by Community Skilled Healthcare Center on [DATE]. The document was signed by Mercy Health Youngstown LLC doing business as Saint [NAME] hospital on [DATE].An interview on [DATE] at 4:15 P.M. with the Administrator verified the signed date on the transfer agreement as finalized on [DATE]. The Administrator stated he did not realize there was a limitation of two years of effect specified within the transfer agreement. The Administrator confirmed the transfer agreement had not been renewed with the hospital (see F843).F. The facility failed to thoroughly conduct a facility-wide assessment with active involvement of all required participants to determine what resources are necessary to care for the residents competently during day-to-day operations. A review of the document titled Community Skilled Facility Assessment with a completion date of [DATE] and a revision date of [DATE] revealed the persons involved in making the assessment were the Administrator, the Director of Nursing and the Medical Director. There was no evidence a member of the governing body, or representatives of the direct care staff also participated in developing the assessment. The document indicated the facility provided care and services to individuals with certain medical and cognitive disabilities. The facility utilized information generated by the minimum data set assessment to determine the care required by the resident population. The document failed to define and address the on-site memory care unit. Further review of the document staffing plan revealed the facility staffing was based on resident population and acuity. The staffing plan did not contain information by unit. In particular, the staffing plan did not address the staffing needed on the memory care unit. Under the area of physical environment, the document failed to address and define the locked memory care unit. Under the area of services and care offered based on resident needs the facility did not ensure and define the locked memory care unit. The assessment also did not address the presence of an activity department. The assessment did not address the needs for specialized activities in the memory care unit.On [DATE] at 3:00 P.M. an interview with RVPN #810 and [NAME] President of Nursing (VPN) #802 verified the facility assessment participants and that the assessment did not address staffing per unit. Both stated the staffing pattern within the assessment was based on a 24-hour period. Both acknowledged there was no staffing to directly address the memory care unit as the staffing pattern should be based on resident acuity as well. RVPN #810 and VPN #802 further verified the facility assessment did not address the presence or definition of the memory care unit. VPN #802 verified the facility assessment did not address the activity department as an additional service provided to the residents of the facility (see F838).G.The facility did not ensure direct care staff had specialized training to work on the memory care unit. Review of personnel files for Certified Nursing Assistants #844, #845, #846 and #860 who were hired between [DATE] to [DATE] had no evidence of specialized training for the memory care unit. An interview on [DATE] at 3:20 P.M. with Human Resource Director (HRD) #804 verified there was no documented evidence of training for the memory care unit for CNAs #844, #845, #846, and #860 within their personnel files. HRD #804 stated the facility did not conduct any specialized training for the memory care unit.On [DATE] between 12:14 P.M. and 12:21 P.M. interviews with CNAs #841, #855, and #866 revealed they had no specialized training for memory care unit (see F949).

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on record review and interview, the facility failed to thoroughly conduct a facility-wide assessment with active involvement of all required participants to determine what resources are necessary to care for the residents competently during day-to-day operations. This had the potential to affect all residents residing in the facility. The facility census was 83.Findings include: A review of the document titled Community Skilled Facility Assessment with a completion date of 02/15/26 and a revision date of 04/13/26 revealed the persons involved in making the assessment were the Administrator, the Director of Nursing and the Medical Director. There was no evidence a member of the governing body, or representatives of the direct care staff also participated in developing the assessment. The document indicated the facility provided care and services to individuals with certain medical and cognitive disabilities. The facility utilized information generated by the minimum data set assessment to determine the care required by the resident population. The document failed to define and address the on-site memory care unit. Further review of the document staffing plan revealed the facility staffing was based on resident population and acuity. The staffing plan did not contain information by unit. In particular, the staffing plan did not address the staffing needed on the memory care unit. Under the area of physical environment, the document failed to address and define the locked memory care unit. Under the area of services and care offered based on resident needs the facility did not ensure and define the locked memory care unit. The assessment also did not address the presence of an activity department. The assessment did not address the needs for specialized activities in the memory care unit.On 04/14/26 at 11:40 A.M. an interview with Regional [NAME] President of Nursing (RVPN) #810 revealed the original facility assessment given to surveyors was under review and revision. RVPN #810 stated it was the responsibility of the Administrator to ensure the accuracy of the facility assessment, but the document was under review and needed revision.On 04/14/26 at 3:00 P.M. an interview with RVPN #810 and [NAME] President of Nursing (VPN) #802 verified the facility assessment participants and that the assessment did not address staffing per unit. Both stated the staffing pattern within the assessment was based on a 24-hour period. Both acknowledged there was no staffing to directly address the memory care unit as the staffing pattern should be based on resident acuity as well. RVPN #810 and VPN #802 further verified the facility assessment did not address the presence or definition of the memory care unit. VPN #802 verified the facility assessment did not address the activity department as an additional service provided to the residents of the facility.

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F 0843 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to have a current transfer agreement with an area hospital. This had the potential to affect all residents residing in the facility. The facility census was 83. Findings include: Review of the facility document titled Transfer Agreement, revealed the transfer agreement was by and between Community Skilled Healthcare Center located at 1320 Mahoning Ave. N.W. [NAME], Ohio 44483 and Mercy Health Youngstown LLC doing business as Saint [NAME] Hospital located at 667 [NAME], [NAME], Ohio 44482. The document further revealed the agreement shall take effect on the date signed by both parties and continue for two years unless terminated by either party within 30 days written notice to the other party. The document was signed by Community Skilled Healthcare Center on 06/01/17. The document was signed by Mercy Health Youngstown LLC doing business as Saint [NAME] hospital on [DATE].An interview on 04/13/26 at 4:15 P.M. with the Administrator verified the signed date on the transfer agreement as finalized on 06/13/17. The Administrator stated he did not realize there was a limitation of two years of effect specified within the transfer agreement. The Administrator confirmed the transfer agreement had not been renewed with the hospital.

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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 record review, interview and facility policy review, the facility failed to ensure care plans were revised in response to resident assessments and physician ordered interventions for Resident #10, Resident #49, Resident #71, and Resident #90. This affected four residents (#10, #49, #71,and #90) of 47 residents reviewed for care plans. The facility census was 83. Findings included:1. Review of the medical record for Resident #10 revealed an admission date of 09/17/22. Resident #10 was hospitalized from [DATE] to 01/13/26 due to a fracture of the right femur post-fall incident on 01/03/26. Further diagnoses included Alzheimer's dementia, hypertension, anxiety, insomnia, and chronic kidney disease.Review of Resident #10's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severely impaired cognition, was independent with eating, and required substantial to maximal assist for oral hygiene, toileting hygiene, showers, dressing. Resident #10 was dependent on staff for putting on and taking off shoes and bed mobility.Review of Resident #10's care plan, last revised 03/31/26, revealed the resident was at risk for falls related to dementia and Alzheimer's, anxiety, advanced age, and at times agitation with hands on care. Interventions included staff ensuring floor mat beside bed and a physical therapy screen dated 01/03/26. The care plan did not identify the fall that occurred on 01/03/26 or Resident #10's right femur fracture nor interventions to address care related to the fracture.An interview on 04/15/26 at 2:55 P.M. with Registered Nurse (RN) #811 revealed she verified Resident #10's care plan was not updated with her most recent fall and injury. 2.Review of the medical record for Resident #49 revealed an admission date of 10/01/25 with diagnoses including spinal stenosis, type two diabetes mellitus, chronic kidney disease (CKD) stage three and alcohol abuse.Review of the progress note dated 01/14/26 at 6:01 P.M. revealed Resident #49 contacted the hospice nurse regarding complaints of burning and itching upon urination. Resident #49 believed she had a Urinary Tract Infection (UTI). New orders for Macrobid (antibiotic for UTI) 100 milligram twice a day (BID) for seven (7) days. Resident #49 updated at bedside and family notified by Hospice nurse.Review of the order dated 01/15/26 revealed an order for Macrobid oral 100 mg capsule to administer one by mouth (PO) BID (twice a day) for seven days for symptoms of itching and burning.Review of the medication administration records (MARS) and treatment administration records (TARS) for January 2026 revealed Resident #49 received her antibiotic per physician orders.Review of the quarterly MDS assessment dated [DATE] revealed Resident #49 had impaired cognition and was always incontinent of bladder and frequently incontinent of bowel.Review of Resident #49's care plan, last revised 04/09/26, revealed there was no revision made to add the diagnosis of UTI nor the physician ordered antibiotic from 01/15/26.An interview on 04/13/26 at 11:43 A.M. with the Director of Nursing (DON) confirmed there was no update to the care plan for UTI or antibiotic for Resident #49.An interview 04/13/26 at 1:04 P.M. with MDS Coordinator #811 confirmed there was no update to the care plan for UTI or antibiotic for Resident #49. 3. Review of Resident #71's medical record revealed an admission date of 01/07/25. Diagnoses included but not limited to spinal stenosis cervical region, lumbar region, impulse disorder, and adjustment disorder with mixed disturbance of emotions and conduct, mood affective disorder.Review of the MDS quarterly assessment dated [DATE] revealed Resident #71 had intact cognition and was occasionally incontinent of bladder and frequently incontinent of bowel.Review of the physician orders dated March 2026 revealed an order to cleanse right upper lateral back with normal saline, apply Medi honey and cover with a dry dressing and cleanse right upper medial back, apply Medi honey and cover with dry dressing.Review of the MARS and TARS for March 2026 and April 2026 revealed Resident #71 received treatments to cleanse right upper lateral back with normal saline, apply Medi honey and cover with a dry dressing and cleanse right upper medial back, apply Medi honey and cover with dry dressing except for refusals.Review of Resident #71's plan of care, (continued on next page)

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Community Skilled Healthcare	1320 Mahoning Ave NW Warren, OH 44483

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	date last revised 04/13/26, revealed the care plan had not been revised to specify Resident #71 had pressure injuries to right upper lateral back and pressure injury to right upper medial back. The care plan indicated has a pressure ulcer as of 03/12/26.An interview 04/13/26 at 11:43 A.M. with the DON confirmed there was no care plan for the pressure injury to right upper lateral back and right upper medial back for Resident #71.An interview 04/13/26 at 1:04 P.M. with MDS Coordinator # 811 confirmed there was no care plan for the pressure injury to right upper lateral back and right upper medial back for Resident #71. 4. Review of the medical record for Resident #90 revealed an admission date of 03/26/26. Diagnoses included unspecified severe protein-calorie malnutrition. Review of the admission MDS assessment dated [DATE] revealed Resident #90 had severely impaired cognition and was always incontinent of bowel and bladder.Review of the April 2026 physician orders revealed an order to change Peripherally Inserted Central Catheter (PICC) Line dressing weekly on day shift and as needed (PRN).Review of the April 2026 MARS and TARS revealed Resident #90's PICC Line dressing change was completed per physician orders. Review of Resident #90's care plan, last revised on 04/07/26, revealed there was no revision made to identify the PICC line dressing changes. An interview 04/13/26 at 11:43 A.M. with the DON confirmed there was no care plan for the PICC Line dressing change. An interview 04/14/26 at 12:23 P.M. with MDS Coordinator #811 confirmed there was no care plan for the PICC Line dressing change. Review of facility policy, Comprehensive Care Plans, revised 01/10/25, revealed the facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, to include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality. The comprehensive care plan will be prepared by an interdisciplinary team (IDT) and reviewed and revised by the IDT after each comprehensive and quarterly assessment.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of facility policy, the facility failed to ensure Resident #78 was provided one-to-one activities to meet personal needs, and failed to ensure all residents residing on the memory care unit (Residents #4, #5, #8, #10, #13 , #14, #16, #17, #23, #30, #40, #42 , #46, #47, #48, #50, #59, #64 , #65, #66, #68, #72, #83, and #84) received a program of therapeutic activities for their highest practical well-being. This affected 25 residents (Residents #4, #5, #8, #10, #13, #14, #16, #17, #23, #30, #40, #42 , #46, #47, #48, #50, #59, #64 , #65, #66, #68, #72, #78, #83, and #84) of 83 residents observed for activities. The facility census was 83. Findings include: A review of the facility activity calendar labeled February 2026 Dementia Unit revealed on 02/01/26 there were no activities on the calendar. The latest activity scheduled for each day on the dementia unit was at 2:00 P.M. unless it was a holiday, then the latest activity was scheduled at 3:00 P.M. There were no special function activities. Beginning on 02/02/26 per this calendar, the following activities were scheduled daily at 10:00 A.M. and 2:00 P.M. : Morning Stretch at 10:00 A.M. and Music Time at 2:00 P.M. every Monday. Beachball Toss or Coloring at 10:00 A.M. and Snack and Chat at 2:00 P.M. every Tuesday. Sensory Time or Coffee Time at 10:00 A.M. and Snack and Chat at 2:00 P.M. every Wednesday. Memory Game or Guess the Song at 10:00 A.M. and Snack and Chat at 2:00 P.M. every Thursday. Nails at 10:00 A.M. and Nails at 2:00 P.M. every Friday. Exercise at 10:00 A.M. and Coloring at 2:00 P.M. every Saturday. On 02/14/26 there was a holiday celebration at 3:00 P.M. Church on TV at 10:00 A.M. and I Spy at 2:00 P.M. every Sunday. Review of the facility activity calendar labeled March 2026 (for the dementia unit) revealed the activity schedule (10:00 A.M. and 2:00 P.M.) remained the same as the February 2026 calendar. There were no special function or evening activities listed except for a Celebration activity added at 3:00 P.M. on 03/17/26 for the holiday. Review of the facility activity calendar labeled April 2026 revealed the facility had one activity calendar and no longer had one specifically designated for the residents residing on the memory care (dementia) unit. The following activities were scheduled daily as follows: Coffee and News at 9:00 A.M., Church on TV at 10:00 A.M., Coloring Packet at 2:00 P.M. and Ice Cream at 3:00 P.M. on Sunday. Coffee and News at 9:00 A.M., Exercise at 9:30 A.M., Gardening at 10:00 A.M., Bingo at 1:30 P.M. and Water Cart at 3:00 P.M. on Monday. Coffee and News at 9:00 A.M., Uno at 10:00 A.M., Puzzles at 1:30 P.M. and Juice Cart at 3:00 P.M., Residents Choice at 4:00 P.M. and 1:1 Room Visits at 6:00 P.M. on Tuesday. Coffee and News at 9:00 A.M., Trivia at 10:00 A.M., Bingo at 1:30 P.M. and Water Cart at 3:00 P.M., Movie at 4:00 P.M. and 1:1 Room Visits at 6:00 P.M. on Wednesday. Coffee and News at 9:00 A.M., Exercise at 9:30 A.M., Nails at 10:00 A.M., Nails at 1:30 P.M. and Water Cart at 3:00 P.M. on Thursday. Coffee and News at 9:00 A.M., Board Games at 10:00 A.M., Bingo at 1:30 P.M. and Juice Cart at 3:00 P.M. on Friday. Coffee and News at 9:00 A.M., St 4 Coffee at 10:00 A.M., [NAME] Baptist 2:00 P.M. and Water Cart at 3:00 P.M. on Sunday. A review of the facility document titled Job Description of Activity Director revealed it was signed by Activity Director (AD) #876 on 04/21/25. The document indicated the Activity Director was a department head directly responsible for the planning, coordinating, supervising, and implementing a (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	meaningful and ongoing activity program that fulfills the physical, social, mental, spiritual, and psychosocial well-being of all residents who choose to participate in a group setting, individually, or on a one-on-one basis. The program shall be in compliance with company policy, as well as with state and federal regulations. Observation was conducted on 04/07/26 between 5:50 P.M. to 6:20 P.M. on the secured memory care unit of the facility. Eight residents were observed lying in their beds. Five residents' rooms were noted with their doors closed so they were not disturbed during the observation period. There were 11 residents sitting in the dining room area not engaged in therapeutic visual, auditory, tactile or other sensory activities to occupy these residents. The observation further revealed that residents in the dining room were becoming increasingly restless and difficult to redirect while aides and nurses were tending to other residents' toileting needs after dinner. An interview with Licensed Practical Nurse (LPN) 807 during this observation revealed structured activities rarely happen on the unit especially at night after dinner. LPN #807 was unable to recall the last time an activity occurred on the memory care unit after dinner and stated there is no activity programming in general for the unit and she does not know why. On 04/08/26 at 8:09 A.M. an interview with LPN #816 revealed that she sometimes works in the memory care unit. LPN #816 stated there are no activities being held in the memory care unit. On 04/08/26 at 9:50 A.M. an interview with LPN #832 revealed the facility was working on activities for the memory care unit. LPN #832 further revealed that sometimes the activity department will bring the residents in the memory care unit ice cream. An observation on 04/08/26 at 9:50 A.M. on the memory care unit revealed no structured, therapeutic activities were taking place on the memory care unit, and there were six residents sitting in the common area in front of a television. On 04/08/26 at 10:00 A.M. an interview with Registered Nurse (RN) #871 revealed there was no dedicated activity calendar for the dementia unit. RN #871 stated it was up to the nursing staff on the unit to do things for the residents, so the residents were going to have a movie at 3:00 P.M. that afternoon and she was the one who planned it and purchased the snacks for the activity. RN #871 further stated planned activities for the memory care unit are rare. On 04/08/26 at 10:45 A.M. an interview with Activity Director (AD) #876 verified on Tuesday, specifically 04/07/26, one-to-one visits were scheduled on the activity calendar at 6:00 P.M., however, the activity staff were scheduled to leave at 4:00 P.M. so those one-to-one visits were not actually done. On 04/08/26 at 1:30 P.M. bingo was observed in the main activity room. An interview with AD #876 and Assistant Director of Nursing (ADON) #803 at the time of the observation revealed there were no residents from the memory care unit present for the bingo activity. Subsequent observation of the memory care unit directly following this observation revealed no activities taking place on the memory care unit. There were four residents sitting in front of the television. On 04/09/26 at 9:45 A.M. there was no activity taking place in the activity room. Per the calendar, the Thursday, 9:30 A.M. activity was exercise. On 04/09/26 at 10:00 A.M. observation of the memory care unit revealed one resident in the common area working with an abacus. An interview with RN #871 at the time of the observation revealed no exercise had taken place in the memory care unit this (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	morning. RN #871 further stated activities did not come down to the unit to take residents to the activity room to participate in the exercise activity as scheduled. On 04/09/26 at 10:10 A.M. an interview with AD #876 revealed she started her position as the AD in March 2025. AD #876 stated she did not keep a record of activity calendars for the memory care unit and confirmed she had none to show from May 2025 through January 2026 of what activities were planned for the residents during that period on the memory care unit. On 04/13/26 at 9:50 A.M. an interview with Activity Assistant (AA) #878 revealed there were no dedicated activities for the memory care unit recently. AA #878 stated he felt it had been approximately two months since there were dedicated activities for the memory care unit. An observation of the memory care unit at the time of the interview revealed one resident (Resident #8) in the common area in a wheelchair with his head down on the table, two residents dozing in recliners in the common area, and two female residents coloring on coloring pages. On 04/13/26 at 1:30 P.M. observation was conducted of four residents from the memory care unit who were observed participating in bingo in the main activity room. Subsequent observation directly following in the memory care unit revealed four residents watching television. An interview with LPN #824 at the time of the observation revealed she worked on the memory care unit often. LPN #824 further stated there have been no planned activities for the memory care unit. LPN #824 stated the memory care unit was going to have root beer floats this afternoon and that activity was planned by the staff of the memory care unit because the activity staff had no activities planned for the unit. LPN #824 stated the memory care staff will try to plan activities and purchase the needed items for the activities. On 04/14/26 at 9:47 A.M. an interview with AA #879 revealed she was the only full-time activity staff person. AA #879 further stated she used to spend a lot of time back in the memory care unit but now she only gets back to the unit when she can. AA #879 stated she was the one who primarily made the activity calendars and she tried to incorporate activities for the memory care unit within the main calendar. AA #879 stated she has had no formal dementia training from the facility and what she knows she has been self-taught by videos or online training. AA #879 stated it has been at least two months since there were dedicated activities in the dementia care unit. On 04/14/26 at 2:00 P.M. residents were observed playing video bowling in the main activity room. There were no residents from the dementia unit per Environmental Service Supervisor #905. Subsequent observation immediately following in the memory care unit revealed there were no activities taking place in the memory care unit. On 04/15/26 at 10:45 A.M. a group activity was taking place in the main activity room. There were no residents from the memory care unit which was verified at the time of the observation by AA #879. On 04/15/26 at 10:57 A.M. an interview with LPN #818 revealed there have been no scheduled activities or dedicated activity staff for the memory care unit. LPN #818 stated the staff in the memory care unit do the best they can for the residents and often plan their own activities for the unit. An observation at the time of the interview revealed two female residents sitting at a table coloring, one resident using an Abacus, and two residents utilizing tactile boards. A review of the facility policy titled, Dementia Care, dated 01/01/25, with the revision date of 11/11/25, revealed it is the policy of the facility to provide the appropriate treatment and services to (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	every resident who displays signs of or is diagnosed with dementia, to meet his or her highest practicable physical, mental, and psychosocial well-being. The policy further stated individualized, non-pharmacologic approaches to care will be utilized, to include meaningful activities aimed at enhancing the resident's well-being. 2. Record review for Resident #78 revealed an admission date of 07/10/23 with diagnoses including Parkinson's Disease, fibromyalgia, hallucinations, stage four pressure ulcer, protein-calorie malnutrition, chronic viral hepatitis C, generalized anxiety disorder, restlessness and agitation. Review of Resident #78's Minimum Data Set (MDS) assessment dated [DATE] revealed a Basic Interview of Mental Status (BIMS) score 03 which indicated severe cognitive impairment. Review of the MDS further indicated Resident #78 was dependent on staff for all Activities of Daily Living (ADLs), bed mobility and transfers. Review of Resident #78's care plan dated 01/13/26 revealed she had little or no activity involvement due to her physical limitations and required one-on-one visits from activity staff. Interventions included Resident #78 was to receive one to three one-on-one visits per week.Review of one-on-one activity logs for the last month through 04/13/26 revealed Resident #78 did not receive any one-on-one visits for that look back period. On 04/08/26 at 10:45 A.M. an interview with AD #876 verified one-to-one visits were scheduled on the activity calendar at 6:00 P.M. and activity staff were scheduled to leave at 4:00 P.M. AD #876 stated on 04/07/26, for example, the one-to-one activity did not get done because staff left at 4:00 P.M. An interview on 04/14/2026 at 2:07 PM with AA #879 revealed she did not complete any one-on-one visits for this resident and further stated the employee who was responsible to complete all one-on-one visits was no longer employed at the facility and had no knowledge if one-on-ones were being completed. The facility was unable to provide a policy related to activities during the survey.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on employee personnel file review, review of the facility assessment, review of the facility policy and interview, the facility failed to ensure staff had specialized training for the memory care unit. This had the potential to affect all residents (Residents #4, #5, #8, #10, #13, #14, #16, #17, #23, #30, #40, #42, #46, #47, #48, #50, #59, #64, #65, #66, #68, #72, #83, and #84) residing in the memory care unit The facility census was 83.Findings include: A review of the personnel file for Certified Nurse Aide (CNA) #844 revealed a date of hire as 01/28/26. Further review revealed CNA #844 had no specialized training for the memory care unit.A review of the personnel file for CNA #845 revealed a date of hire as 02/25/26. Further review revealed CNA #845 had no specialized training for the memory care unit.A review of the personnel file for CNA #846 revealed a date of hire as 07/31/25. Further review revealed CNA #846 had no specialized training for the memory care unit.A review of the personnel file for CNA #860 revealed a date of hire as 02/25/26. Further review revealed CNA #860 had no specialized training for the memory care unit.An interview on 04/13/26 at 3:20 P.M. with Human Resource Director (HRD) #804 verified there was no documented evidence of training for the memory care unit for CNAs #844, #845, #846, and #860 within their personnel files. HRD #804 stated the facility did not conduct any specialized training for the memory care unit.On 04/14/26 between 12:14 P.M. and 12:21 P.M. interviews with CNAs #841, #855, and #866 revealed they had no specialized training for memory care unit.A review of the document titled; Facility Assessment, with a revision date of 04/13/26, revealed the facility routinely serves residents with clinical and functional needs including, but not limited to, cognitive impairment, dementia, and behavioral health diagnoses. The assessment also revealed nurse aides will receive the following core training including dementia management training and resident abuse prevention training, care of the cognitively impaired, and at least 12 hours of training per year to ensure continuing competence.A review of the policy titled; Luxor Dementia Unit Placement Criteria Policy, dated 01/01/25, revealed residents may be considered for placement on the secured dementia/ memory care unit when clinical assessment and interdisciplinary team review determined the resident would benefit from the specialized environment, programming, and supervision provided on the unit.A review of the policy titled; Dementia Care, with a review date of 11/11/25, revealed the facility will provide the appropriate treatment and services to every resident who displays signs of, or is diagnosed with dementia, to meet his or her highest practicable physical, mental, and psychosocial well-being. The policy further stated all staff will be trained on dementia and dementia care practices upon hire, annually, and as needed to ensure they have the appropriate competencies, and skill sets to ensure resident safety and help residents attain or maintain the highest practicable physical, mental, and psychosocial well-being.

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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, interview and observation the facility failed to ensure call lights were within reach for Residents #13, #76, and #84. This affected three (Residents #13, #49, and #84) of three residents reviewed for call lights. The facility census was 83.Findings include:1. Review of Resident #84's medical record revealed an admission date of 01/10/26. Diagnoses included malignant breast cancer, hypothyroidism, hypertension, adult failure to thrive, unspecified dementia, schizophrenia, and age-related osteoporosis.Review of Resident #84's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had impaired cognition. Resident #84 required setup or clean up assistance with eating, partial to moderate assistance with toileting hygiene, oral hygiene, and showering.An observation on 04/06/26 at 10:40 A.M. of Resident #84's call light revealed it was clipped to the privacy curtain out of reach of the resident.An interview on 04/06/26 at 10:41 A.M. with Resident #84 revealed if she had her call light, she would not have to walk down to the nurses' station to tell them what she needed.An interview with Registered Nurse (RN) #861 on 04/06/26 at 10:42 A.M. revealed she verified the call light was clipped to the privacy curtain and not where Resident #84 could reach it.2. Review of Resident #13 medical record revealed an admission date of 08/12/25. Diagnoses included Alzheimer's disease late onset, generalized anxiety, folate deficiency, cognitive communication deficient, hypokalemia, and dementia insomnia.Review of Resident #13's quarterly MDS 3.0 assessment dated [DATE] revealed the resident had impaired cognition, required set-up assistance with eating, supervision or touching assistance with oral hygiene and partial to moderate assistance with toileting and personal hygiene.Observation on 04/06/06 at 10:43 A.M. revealed Resident #13's call light was lying on the over the bed light and not within reach of the resident.An interview on 04/06/26 at 10:45 A.M. with Certified Nursing Assistant (CNA) #839 verified the call light was not within reach of Resident #13 and verified if the call light was within reach, the resident would use it. She then placed the call light within reach of the resident.3. A review of Resident #49's medical record revealed an admission date of 10/01/25 with diagnoses including spinal stenosis, chronic obstructive pulmonary disease (COPD), type II diabetes mellitus, congestive heart failure (CHF), obstructive sleep apnea, atrial fibrillation, major depressive disorder, generalized anxiety disorder, and pulmonary hypertension.Further review of Resident #49's medical record and MDS 3.0 dated 03/01/26 revealed a Brief Interview of Mental Status (BIMS) score of 08 which indicated moderate cognitive impairment. Resident #49 required moderate assistance with bathing and dressing, was dependent for toileting and required moderate assistance with bed mobility and transfers.An observation and interview on 04/06/26 at 10:00 A.M. revealed Resident #49's call light was hanging from the outlet in the wall, and the cord was stuck between the bed and the wall. The resident stated she could not reach her call light from her lying position in the bed.An interview on 04/06/26 at 10:02 A.M. with Environmental Services Worker #911 and Maintenance Worker #919 confirmed the finding that Resident #49 was unable to reach her call light which was stuck between her bed and the wall.A review of the facility's policy titled Call Lights: Accessibility and Timely Response, revised 12/31/25, revealed the staff would ensure the call light was within reach of residents and secured as needed. The policy also stated the call system would be accessible to residents while in their bed or other sleeping accommodations within the resident's room.

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and facility policy review the facility failed to provide written notice of room changes to the resident and family representative. This affected one resident (#79) out of one resident reviewed for room change. The facility census was 83.Findings includeRecord review for Resident #79 revealed an admission date of 07/31/25 with diagnoses including unspecified intellectual disabilities, other seizures, unspecified psychosis not due to a substance or known physiological condition. Effective 03/11/26 Resident #79's brother was listed as Power of Attorney (POA).Review of Resident #79's progress notes revealed on 03/11/26 a social services entry stated, notified resident of room change. Resident is ok with room change. There was no documentation of evidence that Resident #79 received prior written notice of room change and that Resident's POA was provided written prior notice of room change.Review of a nursing note dated 03/17/26 revealed Resident #79 had a room change done, all personals moved and resident's brother aware.Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #79 had moderate cognitive impairment. Resident #79's speech was clear, usually made self-understood, understood others, and had adequate vision.An interview on 04/06/26 at 3:15 P.M. with Resident #79's POA revealed he was notified verbally in person three days after the room change for Resident #79 that occurred on 03/17/26 and was provided nothing in writing about the room change. An interview on 04/14/26 at 9:05 A.M. with Resident #79 revealed he could not recall receiving written notice prior to his room changes or reasons why he changed rooms. An interview on 04/15/26 at 9:15 A.M. with Social Service Designee (SSD) #883 confirmed written notice was not provided to Resident #79 or his POA prior to resident's room changes on 03/11/26 and 03/17/26. SSD #883 stated she did not have a Room Change Notice form to provide residents and family representatives prior to room changes. SSD #883 confirmed the Room Change Policy, date revised 03/16/2026, stated written notice was to be provided to residents and family representatives prior to room changes. Review of the facility policy Change in Room or Roommate, date revised 03/16/26, revealed prior to making a room change or roommate assignment, all persons involved in the change/assignment, such as residents and their representatives, will be given advance notice of such a change as is possible. The notice of a change in room or roommate will be provided in writing; in a language and manner the resident and representative understand and will include the reason(s) why the move or change is required.

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	365412	A. Building B. Wing	04/17/2026

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and facility policy review, the facility failed to ensure residents were free from physical restraints. This affected one resident (Resident #66) of one resident reviewed for physical restraints. The facility census was 83.Findings include:Review of Resident #66's medical record revealed an admission date of 11/20/25. Diagnoses included moderate protein-calorie malnutrition, dementia, hyperlipidemia, mood disorder, urinary retention, age related osteoporosis, Alzheimer's disease, and anxiety disorder.Review of Resident #66's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition but was able to make needs known. Resident #66 required partial to moderate assist with all Activities of Daily Living (ADLs) including eating, showers, personal hygiene, dressing, and bed mobility.Review of Resident #66's care plan dated 02/01/26 revealed the resident was at risk for fluctuations and/or decline with ALDs due to multiple health issues and she was at risk for falls due to impaired safety awareness, age related debility, and potential for side effects of medications. Staff were to anticipate the resident's needs, follow facility fall protocol, medication review with hospice, ensure proper footwear is on when out of bed, and staff were to ensure wheelchair breaks were locked when not in use.Review of Resident #66's physician orders dated April 2026 revealed she was to have a body pillow to left side of bed for body positioning.Observation on 04/06/26 at 9:48 A.M. of Resident #66 revealed she was lying in bed on her back, right side of bed was against the wall, she had two pillowss along her left side tucked under the fitted sheet. Resident #66 was calm at this time and not trying to get out of bed.An interview on 04/06/26 at 9:50 A.M. with Certified Nursing Assistant (CNA) #841 revealed the pillows were placed under the fitted sheet along the left side of the resident to keep the resident in the bed. CNA #841 stated the resident was a high risk for falls and climbs out of bed. They were instructed to put the pillows under the fitted sheet due to resident pulling at them and wanting to hold the pillows if they are above the sheet and they are meant to keep the resident in bed. CNA #841 confirmed the pillows were under the fitted sheet and that the resident was unable to remove them and that there was not a fall mat on the floor next to her bed.An interview on 04/08/26 at 9:45 A.M. with the Assistant Director of Nursing (ADON) #803 revealed she verified Resident #66 was only to have the body pillow alongside her and not under the fitted sheet and stated that was a restraint.Review of the facility policy titled Restraint Free Environment, last revised 10/06/25, revealed it was the policy of the facility that each resident shall attain and maintain his or her highest practicable well-being in an environment that prohibits the use of physical or chemical restraints for discipline or convenience and limits restraint use in circumstances in which the resident has medical symptoms that warrant the use of such restraint. Under the definition of Physical Restraint it referred to any manual method or physical, or mechanical device, material or equipment attached or adjacent to resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints may include, but are not limited to: Applying leg or arm restraints, hand mitts, soft ties, or vests that the resident cannot remove, using bed rails to keep the resident from voluntarily getting out of bed, tucking in a sheet tightly so that the resident cannot get out of bed, or fastening fabric or clothing so that a resident's freedom of movement is restricted.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 residents were notified of bed hold information prior to discharge to the hospital and failed to notify the Ombudsman of hospitalizations. This affected two residents (Residents #2 and #5) of two residents reviewed for hospitalizations. The facility census was 83. Findings include:1.Review of the medical record for Resident #2 revealed an admission date of 08/24/23 with diagnoses including bipolar disorder, gender identity disorder, and borderline personality disorder.Review of the census data within the medical record revealed Resident #2 was hospitalized from [DATE] and returned to the facility on [DATE]. There was no evidence in the record of a bed hold notice. 2.Review of medical record for resident #5 revealed an admission date of 10/14/25 with diagnoses including unspecified dementia.Review of the census data within the medical record for Resident #5 revealed Resident #5 was hospitalized from [DATE] through 04/10/26. There was no evidence in the record of a bed hold notice. On 04/09/26 at 10:05 A.M. an interview with the Administrator revealed there were no bed hold notices for Residents #2 and #5. The administrator further revealed there was no Ombudsman notification for Residents #2, and the Ombudsman had not been notified yet for Resident #5.On 04/09/26 at 3:52 P.M. an interview with Ombudsman #920 revealed she does not receive notification from the facility for residents going to the hospital.Review of the facility document titled Authorization for Admission, undated, revealed residents receiving Medicaid assistance are entitled to 30 bed hold days per year. These bed hold days are paid by Medicaid and are used for hospital stays or therapeutic leave days. If all 30 bed hold days are exhausted prior to the year's, end, it will be the resident and or residence responsible parties' option to pay the facilities current rate for the bed to be held. The resident and or responsible party will be notified before the charge takes effect so a decision may be made to hold the bed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure a care plan was developed to include discharge planning for Resident #77. This affected one resident (#77) of 47 residents reviewed for care plans. The facility census was 83.Findings include: Review of the medical record for Resident #77 revealed an admission date of 01/22/26. Diagnoses included chronic respiratory failure chronic obstructive pulmonary disease, type two diabetes mellitus without complications, and obesity.Review of the modification of admission MDS assessment dated [DATE] revealed Resident #77 was cognitively intact, had adequate hearing, was able to make himself understood, and understood others. Review of progress notes in Resident #77's medical record revealed on 02/06/26 a nursing note indicated Resident #77 wanted to return to his assisted living and he wanted to stay at the facility until renovations were completed. An additional nurse progress note dated 02/20/26 revealed a mini care conference took place in Resident #77's room. Discharge planning was not documented as discussed in this note.An interview on 04/06/26 at 9:54 A.M. with Resident #77 revealed he moved temporarily to the facility after his assisted living (AL) experienced water damage in December 2025, and he was just waiting for the repairs to be finished at the AL so he could return to the AL. Resident #77 stated his discharge plans have not changed and he wanted to return to his AL as soon as the repairs were done.Review of the care plan for Resident #77, last revised on 04/05/26, revealed a care plan had not been developed to address discharge planning.An interview on 04/13/26 at 2:15 P.M. with Social Services Designee (SSD) #883 confirmed Resident #77's discharge plans were to return to his AL once the water damage was repaired. SSD #883 confirmed a discharge plan of care had not been developed for Resident #77. Review of facility the policy titled, Comprehensive Care Plans, revised 01/10/25, revealed the facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, to include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality. The care plan will include the residents preferences for future discharge.Review of facility policy, Comprehensive Care Plans, revised 01/10/25, revealed the facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, to include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality. The comprehensive care plan will be prepared by an interdisciplinary team (IDT) and reviewed and revised by the IDT after each comprehensive and quarterly assessment. The care plan will address the residents' preferences for future discharge and discharge plans.

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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, observation, interview and facility policy review, the facility failed to administer a proper dose of acetaminophen (analgesic) to Resident #60. This affected one (Resident #60) of six residents observed for medication administration. The facility also failed to address x-rays in a timely manner for Resident #10. This affected one (Resident #10) of two residents reviewed for falls. The facility census was 83.Findings include:1.A review of medical records for Resident #60 revealed the date of admission of 01/22/26. Significant diagnosis included osteoarthritis of the knee, unspecified, and pain in unspecified knee. Significant orders included acetaminophen 500 milligrams, give two tablets by mouth two times a day for pain. An admission minimum data set assessment (MDS) dated [DATE] revealed a brief interview for mental status with a score of 13 indicating Resident #60 was cognitively intact. The assessment also revealed Resident #60 received scheduled pain medication. The pain was rated as occasional with a pain scale rating of two (minor or mild pain). A care plan dated 04/01/26 revealed resident #60 had a history of osteoarthritis to the knees. Interventions included give analgesics (medications for pain) as ordered by the physician and monitor for effectiveness. An observation of medication administration on 04/08/26 at 8:09 A.M. revealed Licensed Practical Nurse (LPN) #819 remove a bottle of acetaminophen from the medication cart. The bottle of acetaminophen was noted to be 325 milligrams. LPN #819 removed 2 tablets from the bottle. LPN #819 then dispensed the medication to Resident #60. Upon return to the medication cart LPN #819 was asked to read the dosage on the acetaminophen bottle. LPN #819 verified the dosage given was 325 milligrams, two tablets. LPN #819 further verified resident #60 was to receive two 500 milligram tablets of acetaminophen two times daily. A review of the facility policy titled; Medication Administration dated 04/09/25 revealed medications are administered by licensed nurses or other staff who are legally authorized to do so in this state. Medications are administered in accordance with professional standards of practice. The policy further revealed medications are administered utilizing the six right of medication administration which included right resident, right drug, right dosage, right route, right time, and right documentation. 2. Review of the medical record for Resident #10 revealed an admission date of 09/17/22 with diagnoses including Alzhiermer's dementia, hypertension, anxiety, insomnia, and chronic kidney disease. Review of Resident #10's admission MDS 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition. She was independent with eating and required substantial to maximal assistance for oral hygiene, toileting hygiene, showers, and dressing. She was dependent on staff with bed mobility and putting on and taking off shoes. Review or Resident #10's care plan, last revised on 03/31/26, revealed the resident was at risk for falls related to dementia and Alzheimer's, anxiety, advanced age, and agitation with hand on care. Further review of Resident #10's care plan revealed to minimize risk for falls through the next review date staff were to ensure a floor mat beside (01/03/26) the bed and a physical therapy (PT) screen (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(07/07/25). Review of Resident #10's progress notes dated 01/03/26 to 01/07/26 revealed Resident #10 had an unwitnessed fall in her room on 01/03/26, skin tears to left forearm, left buttocks and thumb were cleansed, and dressing applied. Range of motion assessment was completed with no abnormal findings. A fall report, neurological checks and monitoring was initiated. Family and physician were updated. Resident #10 was given Tylenol for discomfort and follow up pain scale was zero. On 01/07/26 an X-ray of the left hip and shoulder was ordered due to complaints of low to moderate (three to five on scale of one to ten) pain in the left hip area which was relieved to zero pain with Tylenol. The X-ray was negative. Review of the fall incident and related investigation revealed on 01/03/26 Resident #10 had an unwitnessed fall in her room at 7:00 A.M., non-skid socks were on, no contributing environmental factors, no recent medication changes, vitals were normal, skin tears noted to left arm and left buttocks, and thumb. There was no reported pain with range of motion assessments and no abnormal findings upon assessment. Intervention was fall mat to side of bed. Further review of progress notes revealed on 01/08/26 Resident #10 complained of low to moderate (two to five) pain this time on her right hip which was relieved to zero pain with Tylenol. At 12:27 P.M. a right hip, right knee, left shoulder X-ray was ordered. Review of the X-ray results for Resident #10 revealed the results were completed on 01/08/26 at 2:33 P.M. and resulted to the facility on [DATE] at 3:11 P.M. revealing a right femur fracture. Review of progress notes and pain scales dated 01/09/26 revealed Resident #10 was treated with Tylenol at 8:19 A.M. for moderate pain with good effect (follow up pain level two) and was sent to the hospital as noted at 10:09 A.M. An interview on 04/09/26 at 2:40 P.M. with the X-ray company verified the X-ray results for Resident #10 were made available to the facility on [DATE] at 3:11 P.M. An interview on 04/13/26 at 4:47 P.M. with the Director of Nursing (DON) revealed Resident #10's X-ray results were sent to the facility electronically on 01/08/26 at 3:13 P.M. on their communication dashboard in Point Click Care (PCC) and they were not reviewed until the DON noticed they were unreviewed on their electronic dashboard during morning meeting on 01/09/26 at 10:00 A.M. and notified the floor nurse of the results and to send Resident #10 to the hospital because the X-ray results were positive for a fracture. The DON stated X-ray results should have been reviewed on 01/08/26 and promptly notified the physician of the results. Review of the facility policy titled Radiology and other Diagnostic Services and Reporting, last revised 12/02/25, revealed the facility must promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside the clinical reference range.

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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, interviews and record reviews, the facility failed to secure smoking materials for Resident #52. This affected one Resident (#52), who was identified as the facility's only smoker, of one resident reviewed for smoking and had the potential to affect all residents in the facility. The facility's census was 83.Findings include:A review of Resident #52's medical record revealed an admission date of 09/13/24 with diagnoses including chronic obstructive pulmonary disease (COPD), diabetes mellitus type II with hyperglycemia, atherosclerotic heart disease, depression, hypertension (HTN), myocardial infarction (MI), and lesion of the ulnar nerve of the left upper limb.A review of Resident #52's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated intact cognition. Further review of the MDS also revealed Resident #52 required set-up/supervision with all activities of daily living and required supervision with shower transfers and mobility.A review of Resident #52's lone smoking assessment dated [DATE] revealed education was conducted with the resident on safety of smoking including designated smoking areas, designated smoking times, no cigarettes, e-cigarettes or lighters would be kept in resident's room. The smoking assessment further revealed all smoking items were to be kept in a secure location with staff access only.A review of the facility's Resident Sign-Out log on 04/07/26 at 1:15 P.M. revealed Resident #52 signed himself out to smoke several times per day over approximately the last nine months.An interview with Resident #52 on 04/07/26 at 1:29 P.M. revealed he went out to the sidewalk to smoke and signed himself out each time per the facility's policy. The resident further stated he kept his cigarettes and his lighter on his person in his room and had not been instructed to store them locked up at the nurses station.An observation with Resident #52 on 04/07/26 at 1:30 P.M. confirmed his cigarettes and his lighter were stored in a coat pocket in the closet in his room. This observation was confirmed by Certified Nursing Assistant (CNA) #868 on 04/07/26 at 1:31 P.M.An interview with the Administrator on 04/08/26 at 12:30 P.M. revealed the facility's only smoking policy in place was for a Smoke Free Facility. The Administrator further stated there was no current policy in place or available for smoking residents who were grandfathered in before the building became a smoke-free facility.An interview with Regional [NAME] President of Nursing #810 on 04/15/26 at 9:00 A.M. revealed the facility was smoke-free since 01/01/25.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, facility policy review and interview, the facility failed to ensure Resident #9's nasal spray was stored in a safe manner. This affected one (Resident #9) of six residents observed during medication administration. In addition, the facility failed to date a multi-dose vial of Tubersol (a liquid that is used to test if someone has been exposed to tuberculosis) in a manner to preserve efficacy. This had the potential to affect all residents who may require tuberculin skin testing using multi-dose vials. The facility census was 83.Findings include:1. A review of medical records for Resident #9 revealed the date of admission as 02/25/26. Significant diagnoses included chronic diastolic congestive heart failure. Significant orders included Fluticasone (corticosteroid nasal spray) 50 micrograms suspension, use one spray in each nostril daily for allergies. There were no orders to leave medications at the bedside of Resident #9.An admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating Resident #9 was cognitively intact.An observation of medication administration on 04/07/26 at 9:22 A.M. for Resident #9 revealed her Fluticasone nasal spray was located in the top drawer of her bedside table. Licensed Practical Nurse (LPN) #832 verified the nasal spray was located in the top drawer of the bedside table at the time of the observation. LPN #832 stated Resident #9 did not have an order to keep medication at her bedside, nor did Resident #9 have an order for self-administration of the nasal spray.2. An observation of the low three medication storage refrigerator on 04/07/26 at 9:25 A.M. revealed a one milliliter multi-use vial of Tubersol (10 doses) that was opened. The Tubersol vial was not labeled as to when it was opened. LPN #832 verified the opened, undated Tubersol vial at the time of the observation.A review of the manufacturer's package insert for Tubersol revealed vials in use for more than 30 days should be discarded due to possible oxidation and degradation which may affect potency.A review of the facility policy titled; Medication Storage, dated 03/31/25, revealed it is the policy of the facility to ensure all medications housed on the premises will be stored in the pharmacy and or medication rooms according to the manufacturers recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. The policy further stated all drugs and biologicals will be stored in locked compartments.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility policy review and interview, the facility failed to ensure dental services were obtained for Resident #4. This affected one resident (Resident #4) of two residents reviewed for dental services. The facility census was 83.Findings include:A review of the medical records for Resident #4 revealed a date of admission of 03/09/22. Significant diagnosis included Alzheimer's disease with late onset, severe, with agitation.A review of the medical record for Resident #4 revealed a signed consent to treat for dental services dated 01/15/26. The consent to treat was signed by the Power of Attorney (POA) for Resident #4 because she wanted the resident fitted for dentures.A care plan dated 03/11/26 revealed Resident #4 to be edentulous (without teeth) and preferred not to wear dentures. Interventions included dental checkups as ordered.A review of an e-mail sent on 03/17/26 to 360 Dental Services from Social Services (SS) #823 revealed 360 Dental Services was contacted to schedule dental appointments for the facility. 360 Dental Services did not get back to the facility to schedule. A review of an additional e-mail dated 04/09/26 at 5:07 P.M. revealed 360 Dental Services were again contacted about a schedule for the facility. A return e-mail to SS #823 on 04/10/26 at 11:54 A.M. revealed 360 Dental Services would get back to the facility about scheduling an appointment.A quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10 out of 15 indicating Resident #4 had moderate cognitive impairment. The assessment also revealed Resident #4 had no broken or loosely fitting teeth, and no facial or mouth pain.An interview on 04/15/26 at 10:16 AM with SS #823 revealed she had started at the facility in January 2026. SS #823 further revealed 360 Dental was at the facility in February 2026. SS #823 stated she schedules ancillary services for the facility. SS #823 also stated when a resident signed consents, she forwards the consent, insurance information, and a face sheet to 360 Dental and they place them on a list to schedule. SS #823 verified the lack of response from 360 Dental Services with the emails dated 03/17/26 and 04/09/26 to schedule services for the facility. SS #823 further stated she had no tracking procedure in place to ensure residents who had signed consents for dental services were in fact on the dental list to be seen.A review of the facility document labeled; 360 Care Final Appointments Listings for Community Skilled Nursing Center dated 02/06/26 revealed Resident #4 was not on the schedule to be seen despite having a signed consent dated 01/15/26.Interview on 04/15/26 at 10:30 A.M. with SS #823 verified Resident #4 was not on the appointment list dated 02/06/26. A review of the facility policy titled; Dental Services, dated 01/25/25, revealed it is the policy of the facility to assist residents in obtaining routine and emergency dental care. The policy further revealed the facility will, if necessary or requested, assist the residents with making dental appointments.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, record review and facility policy review the facility failed to ensure attractive and palatable pureed food was served to Resident #39. This affected one Resident (#39) of three residents reviewed for food. The facility identified nine residents (#10, #35, #39, #41, #64, #65, #66, #74, #79) as receiving pureed diets. The census was 83.Review of the medical record for Resident #39 revealed an admission date of 04/26/25 with medical diagnoses including diaphragmatic hernia without obstruction or gangrene, other idiopathic peripheral autonomic neuropathy, and moderate protein-calorie malnutrition. The prescribed diet was listed as pureed texture, regular consistency and no added salt. An interview on 04/08/26 at 10:55 A.M. with Resident #39 revealed most days his pureed food was runny and not appealing. Observation on 04/08/26 at 12:39 P.M. of Resident #39's lunch tray revealed there were two pureed food items on the plate that did not hold form. One of the items was a brown circle of runny, thin consistency food (identified as Philadelphia cheesesteak) that was running into and touching a second white food item (identified as onion rings) of runny, thin consistency on the resident's plate. Resident #39 tasted both food items and reported the brown puree had good flavor, however it was too thin and the white puree had no flavor and also too thin. On 04/08/26 at 12:41 P.M. observation of Resident #39 revealed he called the kitchen from his room phone to discuss his lunch tray. Resident #39 explained his pureed food was too thin and the white puree had no flavor. Dietary Aide (DA) #111 confirmed Resident #39 was calling because his pureed food was runny and the white food had no flavor and offered a substitute for the pureed onion rings. Resident #39 requested French fries or mashed potatoes, and DA #111 stated both items were not available and suggested Resident #79 put ketchup on the pureed onion rings. Resident #39 presented with an unhappy facial expression after the call.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365412	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Skilled Healthcare	1320 Mahoning Ave NW Warren, OH 44483

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure influenza and pneumococcal vaccines were addressed and administered timely for Resident #66. This affected one Resident (#66) of seven residents investigated for timely vaccination administration. The facility census was 83.Findings include:A review of Resident #66's medical record revealed an admission date of 11/20/25 with diagnoses including moderate protein-calorie malnutrition, unspecified dementia, unspecified mood disorder, osteoporosis, late onset Alzheimer's disease and anxiety.A review of Resident #66's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Basic Interview for Mental Status (BIMS) score of 10 out of 15 which indicated moderate cognitive impairment. Further review of the MDS revealed Resident #66 required partial to moderate assistance with activities of daily living (ADL) bed mobility and transfers.A review of the immunization records for Resident #66 revealed neither influenza nor pneumococcal vaccines had been addressed or administered even though Resident #66's responsible party had signed consents for both vaccines to be given on 03/06/26.An interview on 04/14/2026 at 12:22 P.M. with the Assistant Director of Nursing (ADON) #803 revealed the admission nurse is expected to get consents for immunizations as part of the clinical admission process. ADON #803 was not sure why a delay occurred with this resident. ADON #803 further revealed the expectation was for the nurse to give immunizations within 30 days from when the consents are received and stated, this one was missed.The facility's policy titled Influenza Vaccination, revised 06/11/25, revealed Influenza vaccinations would be routinely offered annually from October 1^^ through March 31^^ unless such immunization is medically contraindicated, the individual had already been immunized during this time period or refused to receive the vaccine. Additionally, influenza vaccinations would be offered to residents upon availability of the seasonal vaccine until influenza was no longer circulating in the facility's geographic area. Following assessment for potential medical contraindications, influenza vaccinations would be administered in accordance with physician-approved standing orders.The facility's policy titled Pneumococcal Vaccine, revised 06/11/25, revealed each resident would be offered a pneumococcal immunization unless it was medically contraindicated or the resident had already been immunized. Following assessment for any medical contraindications, the immunization would be administered in accordance with physician-approved standing orders.The facility was unable to produce a policy related to standing orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365412	A. Building B. Wing	04/17/2026

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure a COVID 19 vaccine was addressed and administered timely for Resident #66. This affected one Resident (#66) of seven residents investigated for timely vaccination administration. The facility census was 83.Findings include:A review of Resident #66's medical record revealed an admission date of 11/20/25 with diagnoses including moderate protein-calorie malnutrition, unspecified dementia, unspecified mood disorder, osteoporosis, late onset Alzheimer's disease and anxiety.A review of Resident #66's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Basic Interview for Mental Status (BIMS) score of 10 out off 15 which indicated moderate cognitive impairment. Further review of the MDS revealed Resident #66 required partial to moderate assistance with activities of daily living (ADL), bed mobility and transfers.A review of the immunization records for Resident #66 revealed a COVID 19 vaccine had not been addressed or administered even though Resident #66's responsible party had signed consents for the vaccine to be given on 03/06/26.An interview on 04/14/2026 at 12:22 P.M. with the Assistant Director of Nursing (ADON) #803 revealed the admission nurse was expected to get consents for immunizations as part of the clinical admission process. ADON #803 was not sure why a delay occurred with this resident. ADON #803 further revealed the expectation was for the nurse to give immunizations within 30 days from when the consents were received and stated, this one was missed.A review of the facility's policy titled COVID-19 Vaccination, revised 06/11/25, revealed COVID-19 vaccinations would be offered to residents when supplies were available, as per CDC and/or FDA guidelines unless such immunization was medically contraindicated, the individual has already been immunized during this time period, or refused to receive the vaccine. Following assessment for potential medical contraindications, COVID-19 vaccinations for residents would be administered in accordance with physician-approved standing orders.The facility was unable to produce a policy related to standing orders.