STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365416	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ohio Living Westminster-Thurber	717 Neil Avenue Columbus, OH 43215

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on review of the medical record, review of facility investigation, review of witness statements, staff interviews, resident family interviews, and review of policy, the facility failed to ensure a resident was free from neglect, when a severely cognitively impaired nonmobile resident, who was dependent on staff for all activities of daily living (ADLS), was not provided food, drink or assistance with ADLs, including incontinence care for approximately 12 hours. This affected one (#12) of three residents reviewed for potential abuse and neglect. The facility census was 32.Findings include: Review of the medical record for Resident #12 revealed an admission date of 03/23/21. Diagnoses included Alzheimer's disease, anxiety, dementia, malnutrition, muscle weakness, contracture of the right foot, and hypertension. Review of Resident #12's Minimum Data Set (MDS) assessment, dated 04/08/26, revealed the resident was rarely if ever understood and cognition was unable to be assessed for Resident #12. The assessment indicated Resident #12 was dependent on staff assistance for all mobility and transfers and was assessed to in be incontinent of bowel and bladder. Review of Resident #12's care plan, revised 04/09/26, revealed Resident #12 was noted to have bladder and bowel incontinence and was at risk for infection and skin integrity impairment with intervention to monitor bowel movements for color, amount and frequency, assess needs, routine skin assessments, encourage fluids, and give incontinence care routinely and as needed. The care plan, revised 04/23/26, revealed Resident #12 had a functional status deficit related to Alzheimer's disease, malnutrition, muscle weakness and difficulty walking with interventions to sit in her room and watch tv, sit in the dining room and look out the window or sit at the ends of the hall to look outside, the resident requires a Hoyer lift for transfers, the resident requires staff to assist in putting on resident's glasses, the resident requires use of a Broda chair and was dependent on staff for bed mobility, transfers and activities of daily living. Review of notes dated 04/12/26 to 05/05/26 revealed no other mention of care concerns or that Resident #12 was thought to be out of the facility for a period of time. The notes made no mention of the resident being thought to be missing, staff searching for and locating Resident #12 or any contacts made to the family, the Director of Nursing (DON) or the physician. Review of the intake/output report dated 04/12/26 documented Resident #12 ate 51-75% of breakfast and no lunch (marked not taken) and dinner was not documented on the form. Urine output was marked as not taken on 04/12/26 at 11:19 A.M. and 6:06 P.M. and documented as large at 11:14 P.M. Review of the food intake form included hand written amounts of food and fluid intakes. On 04/12/26, it was documented Resident #12 ate 80% of her breakfast and both lunch and dinner were marked out. Review of Resident #12's progress notes revealed a note dated 04/13/26 from Physician #166 who spoke with Resident#12 and Resident #12's daughter during a routine follow-up visit and Resident #12's daughter reported concerns about the care over the weekend and planned to see the DON (Director of Nursing). Review of the facility investigation dated 04/13/26 revealed on 04/12/26, Registered Nurse (RN) #134 was working when a Resident (#5)'s family member informed her she was taking her mom off the unit. RN #134 mistook which resident was leaving the unit and when the aide asked where Resident #12 was, RN #134 informed her she was out with family. When night shift staff arrived they reached out to family due to it getting late and (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	requested an update on when Resident #12 would return. They were informed by family that Resident #12 was not with family and should be at the facility. The DON was contacted and facility staff were instructed to search the facility for Resident #12 who was found on the unit at the end of the hallway looking out the window. A skin assessment was completed on 04/13/26 and hospice and the Physician were notified on 04/13/26 by the DON who also discussed concerns with Resident's family. A second skin assessment was completed, staff were in-serviced, and audits began. The investigation file included a concern form, investigation summary form, intakes and output information from the electronic medical record, the staff schedule for the day under review, a blank training in-service log and information that was presented during the staff education related to verification the resident received care, the skin check assessment and shower sheet and three staff interviews from the day shift nurse (RN #134) and two day shift aides (Certified Nurse Assistant #101 and #137). The investigation did not include evidence of statements from staff working night shift when Resident #12 was found, or from the Director of Nursing. The investigation also did not determine details of when Resident #12 was last seen or at what time she was found. Review of RN #134's witness statement, dated 04/13/26, revealed on 04/12/26 she observed a resident leave the floor with family and was going outside. She reported she did not see Resident #12 the rest of her shift and thought she had been with family. Review of Certified Nurse Assistant (CNA) #137's witness statement, dated 04/13/26, revealed on 04/12/26 she provided morning care for Resident #12 and the resident had breakfast in the dining room. Around lunch time she asked RN #134 where resident was at and was informed family took her off the floor and went outside. At dinner time it was not asked where the resident was as the charge nurse stated she was with her family. Interview on 05/04/26 at 2:39 P.M., with the Director of Nursing (DON) revealed she spoke with Resident #12's daughter about concerns mentioned in the Physician progress note. Interview on 05/04/26 at 3:40 P.M., with the DON and Administrator revealed Register Nurse (RN) #134 was working on 04/12/26, the day shift, was newer to the facility and several residents had family visiting. Resident #5 and #12 both had daughters visiting in blue shirts and they believe she mixed up who the residents/family members matched. The DON and Administrator reported when Resident #5's daughter mentioned to the nurse they were going outside she thought it was for Resident #12. The DON and Administrator acknowledged if the nurse did not know which resident matched which family she should have clarified. The DON and Administrator also reported the nurse observed Resident #5 exit the facility and revealed she was aware Resident #5 had been off the unit for a period of time. The DON and Administrator confirmed no residents had signed out of the facility during this period of time. Resident #5 returned shortly later to the unit and received care as expected and ordered. When night shift staff started work, they received handoff that Resident #12 was still out with family. The evening nurse contacted family asking for an update when Resident #12 would be returning and the family informed the nurse she was not with family and should be at the facility. Staff realized family did not take her out of the facility and contacted the DON and started searching the unit for her. The DON reported she had informed staff to check by the end of the hall nook by the window overlooking the dog park and that was where the resident was located. The DON revealed Resident #12 liked to sit and watch the dog park area and her family frequently took her there. The DON and Administrator revealed Resident #12's family had come in on 04/12/26 and fed her breakfast and prior to leaving placed her at the end of the hall in a nook area with a window over looking a dog park. The DON and Administrator confirmed this nook is on an open area and not hidden behind any closed doors. The DON revealed the family was updated and a skin check was preformed with no negative findings. The DON revealed the family informed her of concerns related to Resident #12's care on 04/12/26 and they had several meetings with the family, conducting an investigation and reported the findings to the family. They revealed it was not identified as neglect or an allegation of neglect as it was not found to be intentional that resident did not receive care for an estimated 10-12 hours on 04/12/26 and was based on a communication issue. Interview on 05/04/26 at 4:25 P.M., with Certified Nurse Assistant (CNA) #137 revealed she was the (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that Resident #12 was taken off the unit and confirmed she did not see Resident #12 the remainder of the shift. Interview on 05/06/26 at 8:20 A.M., with Resident #12's family member revealed she had been at the facility on 04/12/26 from around 8:00 to 9:30 A.M. and before she left, she took her mom to the nook with the window overlook the dog park. Resident #12's family member revealed it was one of Resident #12's favorite spots. Resident #12's family member reported she left the facility around 9:30 A.M. and then around 9:30 P.M. she received a call from the facility nurse (LPN #109) asking her when she was bringing Resident #12 back. Resident #12's family member reported the nurse was informed family did not have the resident and she should still be at the facility as she never left. Resident #12's family member reported she later was informed Resident #12 had been located. Resident #12's family member reported it was concerning Resident #12 was not provided lunch or dinner or anything to drink and was not provided any incontinence care for about 12 hours.Review of facility policy titled Abuse, Neglect, Misappropriation and Crime Reporting, dated 08/14/99, revealed the facility shall take measures to prevent abuse, neglect and mistreatment, caused by anyone including staff, visitors or other individuals. Neglect was defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that were necessary to avoid physical harm, pain, mental anguish or emotional distress. This deficiency demonstrates non-compliance related to Complaint Number 2982137.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on review of the medical record, review of facility investigation and witness statements, staff interviews, resident family interviews, and review of policy, the facility failed to ensure an allegation of neglect was reported to the state agency in the required timeframes. This affected one (#12) of three residents reviewed for potential abuse and neglect. The facility census was 32. Findings include: Review of the medical record for Resident #12 revealed an admission date of 03/23/21. Diagnoses included Alzheimer's disease, anxiety, dementia, malnutrition, muscle weakness, contracture of the right foot, and hypertension. Review of Resident #12's Minimum Data Set (MDS) assessment, dated 04/08/26, revealed the resident was rarely if ever understood, was severely cognitively impaired and was unable to be assessed for Resident #12. The assessment indicated Resident #12 was dependent on staff assistance for all mobility and transfers and was assessed to in be incontinent of bowel and bladder. Review of Resident #12's care plan, revised 04/09/26, revealed the resident was noted to have bladder and bowel incontinence and was at risk for infection and skin integrity impairment with intervention to monitor bowel movements for color, amount and frequency, assess needs, routine skin assessments, encourage fluids, and give incontinence care routinely and as needed. The care plan, revised 04/23/26, revealed Resident #12 had a functional status deficit related to Alzheimer's disease, malnutrition, muscle weakness and difficulty walking with interventions to sit in her room and watch tv, sit in the dining room and look out the window or sit at the ends of the hall to look outside, resident requires a Hoyer lift for transfers, resident requires staff to assist in putting on resident's glasses, resident requires use of a Broda chair and was dependent on staff for bed mobility, transfers and activities of daily living. Review of Resident #12's progress notes revealed a note dated 04/13/26 from Physician #166 who spoke with Resident and daughter during a routine follow-up visit and Resident's daughter reported concerns about the care over the weekend and planned to see the DON (Director of Nursing). Review of the facility investigation dated 04/13/26 revealed on 04/12/26, Registered Nurse (RN) #134 was working when a Resident (#5)'s family member informed her she was taking her mom off the unit. RN #134 mistook which resident was leaving the unit and when the aide asked where Resident #12 was, RN #134 informed her she was out with family. When night shift staff arrived they reached out to family due to it getting late and requested an update on when Resident #12 would return. They were informed by family that Resident #12 was not with family and should be at the facility. The DON was contacted and facility staff were instructed to search the facility for Resident #12 who was found on the unit at the end of the hallway looking out the window. A skin assessment was completed on 04/13/26 and hospice and the Physician were notified on 04/13/26 by the DON who also discussed concerns with Resident's family. A second skin assessment was completed, staff were in-serviced, and audits began. The investigation file included a concern form, investigation summary form, intakes and output information from the electronic medical record, the staff schedule for the day under review, a blank training in-service log and information that was presented during the staff education related to verification the resident received care, the skin check assessment and shower sheet and three staff interviews from the day shift nurse (RN #134) and two day shift aides (Certified Nurse Assistant #101 and #137). The investigation did not include evidence of statements from staff working night shift when Resident #12 was found, or from the Director of Nursing. The investigation also did not determine details of when Resident #12 was last seen or at what time she was found. Review of RN #134's witness statement, dated 04/13/26, revealed on 04/12/26 she observed a resident leave the floor with family and was going outside. She reported she did not see Resident #12 the rest of her shift and thought she had been with family. Review of Certified Nurse Assistant (CNA) #137's witness statement, dated 04/13/26, revealed on 04/12/26 she provided morning care for Resident #12 and the resident had breakfast in the dining room. Around lunch time she asked RN #134 where resident was at and was (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	informed family took her off the floor and went outside. At dinner time it was not asked where the resident was as the charge nurse stated she was with her family.Interview on 05/04/26 at 2:39 P.M. with the Director of Nursing (DON) revealed she spoke with Resident #12's daughter about concerns mentioned in the Physician progress note. She revealed she had an investigation summary completed. Interview on 05/04/26 at 3:40 P.M., with the DON and Administrator revealed Register Nurse (RN) #134 was working on 04/12/26, the day shift, was newer to the facility and several residents had family visiting. Resident #5 and #12 both had daughters visiting in blue shirts and they believe she mixed up who the residents/family members matched. The DON and Administrator reported when Resident #5's daughter mentioned to the nurse they were going outside she thought it was for Resident #12. The DON and Administrator acknowledged if the nurse did not know which resident matched which family she should have clarified. The DON and Administrator also reported the nurse observed Resident #5 exit the facility and revealed she was aware Resident #5 had been off the unit for a period of time. The DON and Administrator confirmed no residents had signed out of the facility during this period of time. Resident #5 returned shortly later to the unit and received care as expected and ordered. When night shift staff started work, they received handoff that Resident #12 was still out with family. The evening nurse contacted family asking for an update when Resident #12 would be returning and the family informed the nurse she was not with family and should be at the facility. Staff realized family did not take her out of the facility and contacted the DON and started searching the unit for her. The DON reported she had informed staff to check by the end of the hall nook by the window overlooking the dog park and that was where the resident was located. The DON revealed Resident #12 liked to sit and watch the dog park area and her family frequently took her there. The DON and Administrator revealed Resident #12's family had come in on 04/12/26 and fed her breakfast and prior to leaving placed her at the end of the hall in a nook area with a window over looking a dog park. The DON and Administrator confirmed this nook is on an open area and not hidden behind any closed doors. The DON revealed the family was updated and a skin check was preformed with no negative findings. The DON revealed the family informed her of concerns related to Resident #12's care on 04/12/26 and they had several meetings with the family, conducting an investigation and reported the findings to the family. They revealed it was not identified as neglect or an allegation of neglect as it was not found to be intentional that resident did not receive care for an estimated 10-12 hours on 04/12/26 and was based on a communication issue. Interview on 05/06/26 at 8:20 A.M., with Resident #12's family member revealed she had been at the facility on 04/12/26 from around 8:00 to 9:30 A.M. and before she left, she took her mom to the nook with the window overlook the dog park. Resident #12's family member revealed it was one of Resident #12's favorite spots. Resident #12's family member reported she left the facility around 9:30 A.M. and then around 9:30 P.M. she received a call from the facility nurse (LPN #109) asking her when she was bringing Resident #12 back. Resident #12's family member reported the nurse was informed family did not have the resident and she should still be at the facility as she never left. Resident #12's family member reported she later was informed Resident #12 had been located. Resident #12's family member reported it was concerning Resident #12 was not provided lunch or dinner or anything to drink and was not provided any incontinence care for about 12 hours.Review of facility policy titled Abuse, Neglect, Misappropriation and Crime Reporting, dated 08/14/99, revealed the facility shall take measures to prevent abuse, neglect and mistreatment, caused by anyone including staff, visitors or other individuals. At any time resident abuse is suspected or alleged an immediate investigation would take place and the proper authorities would be notified. Neglect was defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that were necessary to avoid physical harm, pain, mental anguish or emotional distress. All allegations occurring at the health center involving residents shall be reported to the reported to the department of health.This deficiency was an incidental finding during the investigation of Complaint Number 2982137.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on review of the medical record, review of the facility investigation, review of witness statements, review of facility staff training email, review of staff training records, review of facility audits, staff interviews, resident family interviews, and review of policy, the facility failed to ensure a thorough investigation was completed and corrective action was implemented to correct an incident of neglect, when a severely cognitively impaired nonmobile resident, who was dependent on staff for all activities of daily living (ADLS), was not provided food, drink or assistance with ADLs, including incontinence care for approximately 12 hours. This affected one (#12) of three residents reviewed for potential abuse and neglect. The facility census was 32.Findings include: Review of the medical record for Resident #12 revealed an admission date of 03/23/21. Diagnoses included Alzheimer's disease, anxiety, dementia, malnutrition, muscle weakness, contracture of the right foot, and hypertension. Review of Resident #12's Minimum Data Set (MDS) assessment, dated 04/08/26, revealed the resident was rarely if ever understood and cognition was unable to be assessed for Resident #12. The assessment indicated Resident #12 was dependent on staff assistance for all mobility and transfers and was assessed to in be incontinent of bowel and bladder. Review of Resident #12's care plan, revised 04/09/26, revealed Resident #12 was noted to have bladder and bowel incontinence and was at risk for infection and skin integrity impairment with intervention to monitor bowel movements for color, amount and frequency, assess needs, routine skin assessments, encourage fluids, and give incontinence care routinely and as needed. The care plan, revised 04/23/26, revealed Resident #12 had a functional status deficit related to Alzheimer's disease, malnutrition, muscle weakness and difficulty walking with interventions to sit in her room and watch tv, sit in the dining room and look out the window or sit at the ends of the hall to look outside, the resident requires a Hoyer lift for transfers, the resident requires staff to assist in putting on resident's glasses, the resident requires use of a Broda chair and was dependent on staff for bed mobility, transfers and activities of daily living. Review of notes dated 04/12/26 to 05/05/26 revealed no other mention of care concerns or that Resident #12 was thought to be out of the facility for a period of time. The notes made no mention of the resident being thought to be missing, staff searching for and locating Resident #12 or any contacts made to the family, the Director of Nursing (DON) or the physician. Review of the intake/output report dated 04/12/26 documented Resident #12 ate 51-75% of breakfast and no lunch (marked not taken) and dinner was not documented on the form. Urine output was marked as not taken on 04/12/26 at 11:19 A.M. and 6:06 P.M. and documented as large at 11:14 P.M. Review of the food intake form included hand written amounts of food and fluid intakes. On 04/12/26, it was documented Resident #12 ate 80% of her breakfast and both lunch and dinner were marked out. Review of Resident #12's progress notes revealed a note dated 04/13/26 from Physician #166 who spoke with Resident#12 and Resident #12's daughter during a routine follow-up visit and Resident #12's daughter reported concerns about the care over the weekend and planned to see the DON (Director of Nursing). Review of the facility investigation dated 04/13/26 revealed on 04/12/26, Registered Nurse (RN) #134 was working when a Resident (#5)'s family member informed her she was taking her mom off the unit. RN #134 mistook which resident was leaving the unit and when the aide asked where Resident #12 was, RN #134 informed her she was out with family. When night shift staff arrived they reached out to family due to it getting late and requested an update on when Resident #12 would return. They were informed by family that Resident #12 was not with family and should be at the facility. The DON was contacted and facility staff were instructed to search the facility for Resident #12 who was found on the unit at the end of the hallway looking out the window. A skin assessment was completed on 04/13/26 and hospice and the Physician were notified on 04/13/26 by the DON who also discussed concerns with Resident's family. A second skin assessment was completed, staff were in-serviced, and audits began. The investigation file included a concern form, investigation summary form, intakes and output information from the electronic medical record, the (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff schedule for the day under review, a blank training in-service log and information that was presented during the staff education related to verification the resident received care, the skin check assessment and shower sheet and three staff interviews from the day shift nurse (RN #134) and two day shift aides (Certified Nurse Assistant #101 and #137). The investigation did not include evidence of statements from staff working night shift when Resident #12 was found, or from the Director of Nursing. The investigation also did not determine details of when Resident #12 was last seen or at what time she was found. Review of RN #134's witness statement, dated 04/13/26, revealed on 04/12/26 she observed a resident leave the floor with family and was going outside. She reported she did not see Resident #12 the rest of her shift and thought she had been with family. Review of Certified Nurse Assistant (CNA) #137's witness statement, dated 04/13/26, revealed on 04/12/26 she provided morning care for Resident #12 and the resident had breakfast in the dining room. Around lunch time she asked RN #134 where resident was at and was informed family took her off the floor and went outside. At dinner time it was not asked where the resident was as the charge nurse stated she was with her family. Review of email dated 04/13/26 from facility staff education department to all nursing staff stated all nursing staff must complete a mandatory training located on the fifth floor along with sign in sheets. Review of the training information revealed dated 04/13/26 to 04/30/26 revealed RN #134, LPN #109, CNA #137 and #161 were educated on 04/13/26. Review of the training sign in sheets for additional nursing staff along with daily staff schedules revealed several nurses did not complete the mandatory staff training related to ensuring routine care was completed for all residents. RN #100 did not complete the training and worked 04/29/26, LPN #124 did not complete the training and worked 04/13/26, 04/14/26, 04/17/26, 04/18/26, 04/19/26, 04/23/26, 04/27/26, 04/28/26, 05/01/26, 05/02/26, and 05/03/26, LPN #129 did not complete the training and worked 04/23/26, 04/24/26, and 04/29/26, RN #111 did not complete the training and worked 04/13/26, 04/14/26, 04/17/26, 04/18/26, 04/19/26, 04/23/26, 04/27/26, 04/28/26, 04/30/26, 05/01/26, and 05/02/26, Nursing Supervisor #113 did not complete the training and worked 04/14/26, 04/15/26, 04/16/26, 04/18/26, 04/22/26, 04/23/26, 04/28/26, 04/29/26, 04/30/26, and 05/06/26, RN #135 did not complete the training and worked 04/15/26, 04/18/26, 04/19/26, 04/22/26, 04/23/26, 05/02/26, 05/03/26, and 05/06/26, LPN #152 did not complete the training and worked 04/16/26, 04/20/26, and 04/25/26, LPN #160 did not complete the training and worked 04/17/26, 04/19/26, 04/20/26, 04/24/26, 04/27/26, 05/01/26, 05/02/26, 05/03/26, and 05/05/26, and Unit Manager #139 did not complete the training and worked 04/13/26. A few CNA's signed off on the training but it was only for the facility nurses. Review of the facility audits dated 04/13/26 to 04/30/26 revealed on several dates rounding of all residents on the floor occurred within a one minute period of time. Rounding was also documented as occurring on vacant resident rooms. The form was to be signed by both CNA's and the Nurse on the unit during day shift and majority were missing signatures from with CNA's or nursing staff. Interview on 05/04/26 at 2:39 P.M., with the Director of Nursing (DON) revealed she spoke with Resident #12's daughter about concerns mentioned in the Physician progress note. Interview on 05/04/26 at 3:40 P.M., with the DON and Administrator revealed Register Nurse (RN) #134 was working on 04/12/26, the day shift, was newer to the facility and several residents had family visiting. Resident #5 and #12 both had daughters visiting in blue shirts and they believe she mixed up who the residents/family members matched. The DON and Administrator reported when Resident #5's daughter mentioned to the nurse they were going outside she thought it was for Resident #12. The DON and Administrator acknowledged if the nurse did not know which resident matched which family she should have clarified. The DON and Administrator also reported the nurse observed Resident #5 exit the facility and revealed she was aware Resident #5 had been off the unit for a period of time. The DON and Administrator confirmed no residents had signed out of the facility during this period of time. Resident #5 returned shortly later to the unit and received care as expected and ordered. When night shift staff started work, they received handoff that Resident #12 was still out with family. The evening nurse contacted family asking for an update when Resident #12 would be (continued on next page)

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	365416	A. Building B. Wing	05/07/2026

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	returning and the family informed the nurse she was not with family and should be at the facility. Staff realized family did not take her out of the facility and contacted the DON and started searching the unit for her. The DON reported she had informed staff to check by the end of the hall nook by the window overlooking the dog park and that was where the resident was located. The DON revealed Resident #12 liked to sit and watch the dog park area and her family frequently took her there. The DON and Administrator revealed Resident #12's family had come in on 04/12/26 and fed her breakfast and prior to leaving placed her at the end of the hall in a nook area with a window over looking a dog park. The DON and Administrator confirmed this nook is on an open area and not hidden behind any closed doors. The DON revealed the family was updated and a skin check was preformed with no negative findings. The DON revealed the family informed her of concerns related to Resident #12's care on 04/12/26 and they had several meetings with the family, conducting an investigation and reported the findings to the family. They revealed it was not identified as neglect or an allegation of neglect as it was not found to be intentional that resident did not receive care for an estimated 10-12 hours on 04/12/26 and was based on a communication issue. Interview on 05/04/26 at 4:25 P.M., with Certified Nurse Assistant (CNA) #137 reported she had not received any education related to the incident. Interview on 05/04/26 at 4:42 P.M., with CNA #161 reported no education had been provided since this incident occurred. Interview on 05/06/26 at 8:20 A.M., with Resident #12's family member revealed she had been at the facility on 04/12/26 from around 8:00 to 9:30 A.M. and before she left, she took her mom to the nook with the window overlook the dog park. Resident #12's family member revealed it was one of Resident #12's favorite spots. Resident #12's family member reported she left the facility around 9:30 A.M. and then around 9:30 P.M. she received a call from the facility nurse (LPN #109) asking her when she was bringing Resident #12 back. Resident #12's family member reported the nurse was informed family did not have the resident and she should still be at the facility as she never left. Resident #12's family member reported she later was informed Resident #12 had been located. Resident #12's family member reported it was concerning Resident #12 was not provided lunch or dinner or anything to drink and was not provided any incontinence care for about 12 hours.Interview on 05/06/26 at 11:50 A.M. with the Administrator and the DON confirmed the investigation only contained statements from staff working day shift on 04/12/26 and did not include any statements from the night shift staff or the DON who was contacted regarding resident's whereabouts. They also confirmed specific details on what led to the resident being left without care for 10-12 hours, time stamps for all events, and staff training were not included in the investigation. They confirmed the audits were for the staff (nurses and unit managers) to check that the aides were doing routine rounding and confirmed they appear to be prefilled out with the same time for all rounding to have occurred and also stating rounds occurred on vacant rooms. They also confirmed the educational sign-ins including a training on ensuring residents received timely care and they acknowledged several staff have worked without completing this mandatory training.Review of facility policy titled Abuse, Neglect, Misappropriation and Crime Reporting, dated 08/14/99, revealed the facility shall take measures to prevent abuse, neglect and mistreatment, caused by anyone including staff, visitors or other individuals. At any time resident abuse is suspected or alleged an immediate investigation would take place and the proper authorities would be notified. Neglect was defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that were necessary to avoid physical harm, pain, mental anguish or emotional distress. All allegations of abuse shall be reported immediately and will be investigated. Investigating a claim should include ensuring resident safety, suspend the employee pending the completion of the investigation, and notify family member or legal guardian. The investigation may include interviews with the resident or victim, interviews with the alleged wrongdoer, interviews with other facility staff who may have first hand knowledge, interviews with other residents, families and visitors and written statements should be obtained.This deficiency was an incidental finding during the investigation of Complaint Number 2982137.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of the medication administration policy, the facility failed to ensure a resident was free from significant medication errors. This affected one (#34) of three residents reviewed for medication administration. The facility census was 32.Findings include: Review of Resident #34's medical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included hemiplegia and hemiparesis (paralysis and weakness) following cerebral infarction (stroke), non-Hodgkin's lymphoma, chronic pain, and dysphagia (difficulty swallowing) amongst other diagnoses. Further review of Resident #34's medical record revealed the resident was assessed as having severely impaired cognition upon admission.Review of Resident #34's physician orders revealed an order for Oxycodone (pain medication) five milligram (mg) tablets, one tablet to be given every eight hours scheduled at 12:00 A.M., 8:00 A.M., and 4:00 P.M. with a start date of 07/02/25 and an end date of 07/04/25. Further review of physician orders found in Resident #34's medical record revealed multiple orders for different doses of morphine (pain medication) liquid solution at a strength of 100 mg per every five milliliters (ml). The medical record contained orders for morphine 100 mg/5 ml liquid solution to be given at the following doses: 0.5 ml every two hours as needed for pain (start 07/04/25, end 07/05/25), 0.5 ml every shift as needed (start and end 07/04/25), 0.75 ml give one dose at 8:00 A.M. (start and end 07/05/25, 0.75ml every two hours as needed for pain (start and end 07/05/25), and 1.0ml (20mg) every two hours as needed (start 07/05/26, end 07/06/26).Review of the Controlled Drug Receipt/Record/Disposition Form for Oxycodone 5 mg tablets for Resident #34 revealed Oxycodone 5 mg was documented as dispensed from storage and given at or after 1:22 A.M. on 07/04/25.Review of the Controlled Drug Receipt/Record Disposition Form for Morphine Concentrate 100 mg/5 ml liquid for Resident #34 revealed 0.25 ml of morphine was dispensed and given at or after 6:15 A.M. on 07/05/25.Interview on 05/06/26 at 6:00 P.M. with the Director of Nursing (DON) verified Oxycodone was administered late, outside of the ordered timeframe even with consideration to the one-hour grace period before and after the ordered administration time of 12:00 A.M., when the every eight hours scheduled Oxycodone tablet was administered to Resident #34 at 1:22 A.M. on 07/04/25. Further interview with the DON at this time revealed there was no order found in Resident #34's medical record that indicated the resident should have been administered 0.25 ml of morphine concentrate as was documented on 07/05/25 at 6:15 A.M.Review of the facility policy titled Medication Administration, effective 10/01/01 and last revised 02/06/26, revealed medication administered to residents must be ordered by a physician.This deficiency represents non-compliance investigated under Complaint Number 2568205.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, staff interview, and policy review, the facility failed to ensure food was held and served at safe and appetizing temperatures. This had the potential to affect 32 of 32 residents who receive food from the kitchen. Facility census was 32. Findings include:Observation and interview on 05/05/26 from 11:47 A.M. to 12:10 P.M., with Kitchen Manager #81 revealed the facility was serving a turkey club sandwich (cold), coleslaw (cold), gelatin (cold) and loaded potato soup (hot) for lunch. The temperatures were taken at the time the test tray was made and found the turkey club sandwich had a temperature of 53 degrees. It was placed back in the freezer to cool and a new tray was removed from the freezer to serve and sandwiches held a temperature of 43 to 45 degrees. Kitchen Manager #81 returned the tray to the freezer and reported they needed to cool a bit more prior to service. Majority of the lunch trays for the 400 hall cart were already made and placed on the cart for service and came from the sandwich tray with a holding temperature of 53 degrees. These remained on the service cart and was served to resident on the 400 hall. Additional food temperatures at time of service included soup at 167 degrees, coleslaw at 38.8 degrees, and gelatin with cream cheese topping at 39.1 degrees. The test tray left the kitchen at 12:10 P.M. and Kitchen Manager confirmed the food (sandwiches) were not held at the correct temperature. Observation on 05/05/26 from 12:10 to 12:25 P.M., with Kitchen Manager #81 revealed upon arrival to the nursing unit the trays were passed out by staff with the last tray being passed out at 12:20. At that time the test tray had temperatures checked with reading for the sandwich at 59.7 degrees, the soup had a temperature of 126.3 degrees the coleslaw had a temperature of 54.6 degrees and the gelatin had a temperature of 54.7 degrees. Upon taking temperatures Kitchen Manager #81 stated that's not good. when several items were in the mid to high 50 degree range. He stated cold foods should be held and served under 48 degrees. The Kitchen Manager also stated he was surprised the gelatin and coleslaw had such a drastic temperature changes from 38 and 39 degrees to over 54 degrees. The test tray was tasted and the sandwich, coleslaw and gelatin were not cold but tasted closer to room temperature. Review of facility policy titled Food Temperatures dated 2023, revealed temperatures should be taken periodically to ensure cold foods stay below 41 degrees during the holding and plating process until food leaves the service areas. Food should be transported quickly to maintain temperatures for delivery service. Food prep areas shall follow these methods: hold food at or below 41 degrees and food sent to the unit for distribution shall be transported and delivered to the unit maintaining temperature at or below 41 degrees. This deficiency represents non-compliance investigated under Complaint Number 2568205.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to maintain an accurate complete medical record for medication administration of narcotics to a resident. This affected one (#34) of three residents reviewed for completeness and accuracy of the medical record. The facility census was 32.Findings include:Review of Resident #34's medical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included hemiplegia and hemiparesis (paralysis and weakness) following cerebral infarction (stroke), non-Hodgkin's lymphoma, chronic pain, and dysphagia (difficulty swallowing) amongst other diagnoses. Further review of Resident #34's medical record revealed the resident was assessed as having severely impaired cognition upon admission.Review of physician orders for Resident #34 revealed an order for a dose of 0.5 milliliters (ml) of morphine liquid concentration at a strength of 100 milligrams (mg)/5 ml to be given each day every shift as needed for pain, with a start date of 07/04/25 and an end date of 07/04/25. Further review of physician orders contained in Resident #34's medical record revealed an order for 0.75 milliliters (ml) of morphine concentrate at the same strength of 100 milligrams (mg) per five ml to be given one time at 8:00 A.M. on 07/05/25.Review of nursing progress notes contained in Resident #34's medical record revealed a nurse's note from 07/04/25 at 10:41 P.M. that read Hospice nurse came back with new order for morphine 100 mg per 5 ml to be given as needed. Administer 0.5 ml by mouth everyday and every shift. 0.5 ml given at 10:40 P.M. today.Review of Resident #34's Medication Administration Record (MAR) for 07/04/25 revealed no documentation to show the administration of 0.5 ml of morphine concentrate 100 mg/5 ml as was mentioned in the nursing progress note from 07/04/25 at 10:41 P.M. Review of Resident #34's Medication Administration Record (MAR) for 07/05/25 revealed no documentation that 0.75 ml of morphine concentrate 100 mg/5 ml was given on 07/05/25 at 8:00 A.M. as ordered.Review of the Controlled Drug Receipt/Record/Disposition form for morphine 100 mg/5 ml for Resident #34 revealed a dose of 0.75 ml was dispensed at 8:15 A.M. on 07/05/25. Further review of this form revealed directions at the top of the page that read each dose signed for here requires charting on the medication record.Interview with the Director of Nursing (DON) on 05/06/26 at approximately 6:05 P.M. verified although both medications were documented in some other way (on the narcotics sign out sheet for the 0.75 ml dose, progress notes for 0.5 ml dose), there was no documentation as required on Resident #34's Medication Administration record (MAR) that showed administration of 0.5 ml morphine on 07/04/25 at 10:41 P.M. or 0.75 ml of morphine for the ordered 8:00 A.M. dose on 07/05/25.This deficiency represents non-compliance investigated under Complaint Number 2568205.