STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365418	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Countryside Manor Nursing and Rehabilitation LLC	1865 Countryside Drive Fremont, OH 43420

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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 medical record review, staff interview, and review of facility policy, the facility failed to ensure resident representative and physician notification after a change in condition. This affected two (#62 and #76) of two residents reviewed for notification. The facility census was 65. Findings include: 1. Review of the medical record revealed Resident #62 was admitted on [DATE] with reentry on 07/01/24. Diagnoses included conversion disorder with seizures or convulsions, hyperlipidemia, malignant neoplasm of thyroid gland, dementia, major depression, anxiety disorder, cerebral aneurysm, and hypertension. Review of the Minimum Data Set (MDS) assessment, dated 02/03/26, revealed the resident was cognitively intact. Review of nursing progress note, dated 07/23/25, revealed Resident #62 was sent to the emergency room for evaluation. The resident was having slurred speech, was weak, and trembling while trying to walk. Resident #62's blood pressure was slightly elevated and resident stated the writer had two faces. The on-call physician was notified and resident was sent to the emergency room for evaluation. There was no documentation of the family being notified. Review of nursing progress note, dated 11/28/25, revealed Resident #62 was standing in the hallway with a fixed stare, slurring words, and appearing very weak. Resident #62 was assisted back inside the room and place in a recliner. Staff sat with the resident providing one on one care. The resident then began having convulsions lasting approximately one minute. Vitals were obtained and were within normal limits. Staff sat with the resident until she became more alert. After becoming more alert she requested some Tylenol for a headache. The floor nurse was updated and Tylenol was provided. There was no documentation of family or physician notification of this episode. Review of nursing progress note, dated 12/09/25, revealed Resident #62 had seizure activity today at approximately 10:45 A.M. Vitals were within normal limits and the resident came to within a couple of minutes. The nurse encouraged the resident to rest in bed, call light in reach. Review of nursing progress note, dated 12/09/25, revealed Resident #62 had a second seizure like activity in the dining room at approximately 2:30 P.M. Vitals were within normal limits and the nurse brought the resident back to her room. Encouraged her to rest in her chair and use her call light if she needed anything. There was no documentation of family or physician notification of either episode. Review of nursing progress note, dated 03/28/26, revealed Resident #62 reported and presented with seizure like activity. The resident had some tremors to hands and slurred slowed speech noted. The resident reported she just had a seizure. The writer inquired what that was like from her perspective (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and the resident reported she generally has a headache when she seizes and the headache had since resolved. The writer sat with the resident through lunch and the resident's speech became clear, the tremors resolved, and the resident reported being fine. The tablet was not connecting for telehealth notification and a fax was sent to the physician's office. There was no documentation of the family being notified. Interview on 05/14/26 at 9:48 A.M. with the Director of Nursing (DON) verified on 12/09/25 there was no physician notification and no family notification on 07/23/25, 12/09/25, or 03/28/26. Interview on 05/19/26 at 11:58 A.M. with MDS Coordinator #163 verified on 11/28/25 family and physician notification did not occur. 2. Review of medical record revealed Resident #76 had an admission date of 01/24/25 and discharge date of 12/18/25. Diagnoses included acute osteomyelitis of right ankle and foot, history of falling, disorders of bone density and structure, and fibromyalgia. Review of MDS dated [DATE] revealed the resident was cognitively intact. Review of health status note dated 10/27/25 as a late entry revealed the resident was witnessed to slide to the floor from the wheelchair. The resident was waiting to return to bed after being unable to eat lunch due to emesis. The resident's vital signs were blood pressure 116/46, heart rate 18 and matched a radial pulse. Pedal pulses were present but faint due to edema. Respiratory rate was 18 and oxygen saturation was low at 83 percent (%) on three liters per nasal cannula. Resident #76 complained of pain to left side and hip and the left leg was abducted at an odd angle. Emergency Medical Service (EMS) called for the resident to be transferred to the hospital for evaluation and treatment. The Certified Nurse Practitioner (CNP) and the Assistant Director of Nursing (ADON) were notified at the time of the fall. There was no documentation the family was notified of the fall. Review of health status note dated 10/30/25 at 6:18 P.M. revealed the CNP gave an order to send the resident out the Emergency Department (ED) for decreased mobility to upper extremity due to pain and swelling. The resident transferred to the ED for evaluation and treatment. There was no documentation the family was notified of the swelling to the arm and the transfer Review of health status note dated 10/31/25 at 6:06 A.M. revealed the resident returned from the hospital via stretcher at 11:05 P.M. The left arm was in a sling related to possible radial head fracture. The on call CNP was aware of the residents return and condition. There was no documentation the family was notified of the resident's return. Interview on 05/19/26 at 9:42 A.M. with MDS Coordinator #163 verified there was no family notification for the fall on 10/27/25, the transfer to the hospital on [DATE] for swelling in the left arm, or when the resident returned from the hospital on [DATE]. Review of the facility policy titled Acute Condition Changes-Clinical Protocol, revised March 2018, revealed the nursing staff will contact the physician based on the urgency of the situation. For emergencies they will call or page the physician and request prompt response (within approximately one-half hour or less). This deficiency represents noncompliance investigated under Complaint Numbers 2577994 and 2667933.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure resident privacy was provided during incontinence care. This affected one (#9) of 20 residents observed for privacy in a facility census of 65. Findings include: Review of the medical record for Resident #9 revealed and admission to the facility on [DATE]. Diagnoses included dementia, transient ischemic attack, cerebral infarction, spinal lumbar stenosis, anxiety disorder, paranoid schizophrenia, major depression, intellectual disability, congestive heart failure, hypertension, and polyarthritis.Review of the Minimum Data Set assessment dated [DATE] revealed Resident #9 with intact cognition and was dependent on staff for the completion of activities of daily living. Observation on 05/13/26 at 11:25 A.M. revealed Activity Aide #146 propelled Resident #9 in his wheelchair to his room, activated the call light, and proceeded to exit the room. At 11:26 A.M. Certified Nurse Aide (CNA) #170 and CNA #181 responded to Resident #9 room. CNA #181 stated Resident #9 was requesting to use the toilet. Resident #9 was noted to be incontinent of urine through his pants and onto the mechanical lift sling in the wheelchair. CNA #181 and CNA #170 proceeded to transfer Resident #9 to his bed using the mechanical lift. The CNAs removed Resident #9's heavily soiled pants, brief and mechanical lift sling. Resident #9's bed was located within three feet of an exterior window which looked out onto the resident smoking area and associated patio. The curtains remained opened exposing Resident #9's perinium during incontinence care. Resident #9 was then positioned to his left side exposing his buttock and a moderate amount of incontinent formed stool. CNA #170 summoned Licensed Practical Nurse (LPN) #108 to the room and LPN #108 proceeded to apply a zinc barrier cream to the reddened skin. CNA #170 and CNA #181 proceeded to place a new incontinence brief and pants to Resident #9. No attempts to close the blind to the window occurred throughout the entire procedure. Interview with CNA #181 and CNA #170 on 05/13/26 at 12:07 P.M. verified the curtain was left open and Resident #9 was not provided with sufficient privacy when he was exposed during incontinence care. Review of facility policy titled Dignity, revised February 2021, revealed staff promote, maintain and protect privacy, including bodily privacy during assistance with personal care and during treatment procedures. This deficiency represents noncompliance investigated under Complaint Numbers 2999106, 2589881, and 2583063.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on review of Self-Reported Incidents (SRIs), review of facility investigation, interviews, and policy review the facility failed to report misappropriation of controlled substances for destruction to the State Survey Agency. This affected ten (#82, #83, #84, #85, #86, #87, #88, #89, #90, and #91) of 20 residents reviewed for controlled substances for destruction. The facility census was 65.Findings include:Review of the facility investigation dated 11/14/24 revealed controlled medications removed from use for disposal were not present in the facility and there was no evidence of destruction. The following medications were missing: nine oxycodone/acetaminophen 5/325 milligram (mg) tablets and 59 oxycodone/acetaminophen 5/325 mg tablets for Resident #82; 60 oxycodone 5 mg tablets and five oxycodone tablets for Resident #83; 11 oxycodone 5 mg tablets for Resident #84; 10 oxycodone/acetaminophen 5/325 mg tablets, 11 oxycodone/acetaminophen 5/325 mg tablets, and 42 oxycodone/acetaminophen 5/325 mg tablets for Resident #85; 33 oxycodone 10 mg tablets for Resident #85; 14 oxycodone 5 mg tablets for Resident #87; 10 oxycodone 5 mg tablets for Resident #88; 40 oxycodone 5 mg tablets for Resident #89; 32 oxycodone/acetaminophen 7.5/325 mg tablets for Resident #90; and Resident #91 was missing one hydrocodone 7.5/325 mg tablets, 56 hydrocodone/acetaminophen 7.5/325 mg tablets, and two hydrocodone 7.5/325 mg tablets.Review of facility SRIs revealed no SRI was reported on or around 11/14/24 for misappropriation of medications.Interview on 05/12/26 at approximately 3:45 P.M. Regional Clinical Director (RCD) #508 revealed they don't report a drug diversion to the Ohio Department of Health (ODH) as a SRI. RCD #508 stated they reported it to the Ohio Board of Nursing and the Pharmacy Board. RCD #508 stated she was not a part of whether the medications were credited back to the residents and if the facility paid for them. RCD #508 stated the medications were not active medications and they were set to be destroyed.Interview on 05/19/26 at 11:45 A.M. the Administrator stated the facility did not report the missing narcotics as misappropriation to ODH as the residents were no longer at the facility. The medications became the facility's property and not the residents since they were going to be destroyed. The Administrator stated if a resident was discharged to home they send the medications with them. Administrator stated the facility notified the local police department, Ohio Board of Nursing, and the Pharmacy Board.Review of policy titled Abuse and Neglect Protocol, dated 06/13/21, revealed it is the responsibility of our employees, facility consultants, attending physicians, family members, visitors, etc., to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management. Misappropriation of resident property is defined as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of resident's belongings or money without the resident's consent. If an incident of suspected abuse occurs, facility shall report immediately, but not later than two hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury to designated state agency. An immediate investigation will be made and a copy of the findings of such investigation will be provided to the state agency within five working days or as designated by state law.This deficiency represents noncompliance investigated under Incident Number 2970249.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to ensure activities of daily living (ADL) care with removal of facial hair was provided to one (#49) of three residents reviewed for ADLs. The facility census was 65. Findings include: Review of the medical record revealed Resident #49 was admitted on [DATE] with reentry on 10/15/24. Diagnoses included multiple sclerosis, Alzheimer's disease, and major depressive disorder. Review of the Minimum Data Set assessment, dated 03/23/26, revealed the resident had moderate cognitive impairement and required partial/moderate assistance with personal hygiene. Observation on 05/12/26 at 7:53 A.M. of Resident #49 revealed the resident had numerous and long facial hair on her upper lip and chin. Interview on 05/13/26 9:01 A.M. with Resident #49 verified she would like to have her facial hair shaved. Observation on 05/14/26 at 11:33 A.M. of Resident #49 revealed the resident continued to have numerous and long facial hair. Interview on 05/14/26 at 11:35 A.M. with Unit Manager #125 verified Resident #49 had a shower on the prior day. Unit Manager #125 verified Resident #49 had noticeable facial hair on her upper lip and chin. This deficiency represents non-compliance investigated under 2583063, 2589881, 2618793, and 2791151.

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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, interview, and policy review, the facility failed to ensure orders were obtained for the use of a sling and failed to ensure follow up orthopedic consults were obtained for one (#76) of four residents reviewed for falls. The facility census was 65.Findings include:Review of medical record for Resident #76 revealed an admission date of 01/24/25 and discharge date of 12/18/25. Diagnoses included coronary artery disease, congestive heart failure, and chronic kidney disease.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact.Review of health status note dated 10/30/25 at 6:18 P.M. revealed the Certified Nurse Practitioner (CNP) gave orders to send the resident to the Emergency Department (ED) for decreased mobility to left upper extremity due to pain and swelling. The resident transferred to the ED for evaluation and treatment.Review of ED documentation dated 10/30/25 revealed Resident #76 presented with a fall. The resident complained of left arm pain and general body aches after a fall three days ago where she was seen in the. The right side was x-rayed initially because the resident was complaining of right sided pain, Today she is complaining of the left side having pain. The resident denies any new falls or injury. Swelling was observed to the left forearm. An X-ray of left forearm revealed equivocal impacted fracture of radial head. X-ray of the left elbow revealed questionable radial head fracture. Recommend follow-up radiographs in seven to ten days.Review of health status note dated 10/31/25 at 6:06 A.M. revealed the resident returned from the hospital via stretcher at 11:05 P.M. Review of the physician visit progress note dated 11/03/25 at 8:00 A.M. revealed the resident was sent out to the ED for a large amount of swelling to her left arm into wrist and hand. Resident was unable to move her fingers and entire left upper limb with attempts to move being very painful. The resident was x-rayed and there was a concern for a left radius fracture. The resident returned to the facility with a sling. The resident is to have orthopedics follow her.Further review of the medical record revealed no physician order for the sling to left arm and no evidence an orthopedic consult was made for the resident.Interview on 05/19/26 at 9:24 A.M. with MDS Coordinator #163 verified there were no physician orders regarding the sling to the left arm or any evidence an orthopedic consult was obtained.Review of policy titled Acute Condition Changes-Clinical Protocol, revised March 2018, revealed the staff will monitor and document the resident progress and responses to treatment, and the physician will adjust treatment accordingly and the physician will help the staff monitor a resident with a recent acute change of condition until the problem or condition has resolved or stabilized.This deficiency represents noncompliance investigated under Complaint Number 26679933 and 1321980.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, medical record review, staff interview, and facility policy, the facility failed to ensure fall prevention interventions were implemented for two (#9, #32) of three residents reviewed for fall prevention. In addition, the facility failed to ensure resident smoking assessments were completed affecting two (#13, #40) of two residents reviewed for smoking. The facility identified 11 residents (#13, #20, #29, #36, #40, #42, #52, #56, #58, #61, and #64) as smokers in a facility census of 65. Findings Include: 1. Review of the medical record revealed Resident #9 admitted to the facility on [DATE]. Diagnoses included dementia, transient ischemic attack, cerebral infarction, spinal lumbar stenosis, anxiety disorder, paranoid schizophrenia, major depression, intellectual disability, congestive heart failure, hypertension, and polyarthritis. Review of the Minimum Data Set assessment dated [DATE] revealed Resident #9 with intact cognition, psychosis related hallucinations and delusions, range of motion impairment on one side upper and lower extremities, dependent on staff for the completion of activities of daily living including bed mobility and transfer, always incontinent of bowel and bladder, utilized a wheelchair independently for mobility, and experienced two or more falls since admission. Review of nursing plan of care revised 03/26/25 to address Resident #9 risk of falling. Interventions included replace dycem to wheelchair (initiated 02/19/26). New interventions on 05/02/26 included to place dycem between bottom and mechanical lift pad with a sign to be hung by the wheelchair to remind staff to properly place dycem.Review of the Visual/Bedside Kardex, undated, under the area of safety noted instructions to replace dycem to wheelchair as needed. Review of the fall risk assessment dated [DATE] fall risk assessment revealed Resident #9 to have a high risk with multiple falls. Review of interdisciplinary team (IDT) post fall incident investigation summary noted an incident dated 05/02/26 at 6:30 A.M. The resident's wheelchair does not tilt back so he is able to lean forward and slide out of the chair. The resident's wheelchair was not locked. New intervention/Care plan decision included dycem between resident and lift sling and chair. Review of IDT note on 05/04/26 at 9:47 A.M. documented fall from 05/02/26 reviewed per IDT. Resident found in dining room on floor on his buttocks in front of the wheelchair. Resident stated he could get up and move by himself. Staff educated this is not accurate and he needed to ask for assistance. Observation on 05/13/2026 at 11:26 A.M. noted Certified Nurse Assistant (CNA) #170 and CNA #181 respond to Resident #9's room. Resident #9 was seated in a wheelchair with a Hoyer lift sling placed under him in the seat of the chair. CNA #170 and CNA #181 proceeded to transfer the resident to his bed with the Hoyer lift. No dycem was in place between the resident and his sling or under the sling on the chair seat. CNA #181 provided Resident #9 with care in the bed and proceeded to place the lift sling under the resident with no dycem placed. No sign was observed to be posted in the room to remind the staff to place the dycem. Interview at the time of the observation on 05/13/2026 at 11:26 A.M. with CNA #170 and CNA #181 at the time verified no dycem was in place as per the care plan. CNA #170 and CNA #181 also verified no sign was in Resident #9's room to remind staff to properly place dycem. CNA #170 and CNA #181 stated no dycem was available in Resident #9's room and both were unaware dycem was to be placed between the resident and Hoyer lift sling. On 05/13/26 at 12:14 P.M. interview with Licensed (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Practical Nurse (LPN) #108 verified dycem was not in place to Resident #9 as indicated in the fall prevention plan of care. Review of facility policy titled Falls Clinical Protocol, revised September 2012, noted based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. 2.Review of medical record for Resident #32 revealed an admission date of 12/08/20. Diagnoses included bilateral primary osteoarthritis of knee, congestive heart failure, dementia, and chronic kidney disease. Review of the MDS assessment dated [DATE] revealed the resident was cognitively intact. Review of care plan dated 05/19/26 revealed the resident was at risk for falls related to deconditioning, gait/balance problems, history of falls, medication side effects, and noncompliance with waiting for assistance with ransfers. Interventions included keep bed in lowest position with mat on each side of the bed, non-skid strips in front of the toilet, and sign in bathroom reading call before you fall. Observation and interview on 05/11/26 at 10:28 A.M. of Resident #32 revealed the resident lying in bed with a visitor sitting in folding chair beside the bed. Bed was observed to be in a high position with no mats were on the floor. Observation on 05/18/26 at 2:25 P.M. of Resident #32's room revealed no mats were present in the room. Interview on 05/18/26 at 2:27 P.M. with CNA #103 verified there were no mats in Resident #32's room. CNA #103 stated the resident's bed had been moved a while ago and they may have taken the mats out at that time. Interview on 05/19/26 at 9:24 A.M. with MDS Coordinator #163 verified the care plan for Resident #32 still had interventions for mats to both sides of the bed for fall intervention. Review of policy titled Falls-Clinical Protocol, revised September 2012, revealed the staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. If interventions have been successful in preventing falling, the staff will continue with current approaches or reconsider whether these measures are still needed if the problem that required the intervention is resolved. 3. Review of medical record for Resident #40 revealed an admission date of 03/12/26. Diagnoses included nicotine dependence cigarettes. Review of the MDS assessment dated [DATE] revealed the resident had moderate cognitive impairment. Review of care plan dated 03/25/25 revealed the resident was smoker. Interventions included smoking assessment quarterly and as necessary. Review of smoking safety evaluation dated 03/12/26 revealed the resident was a smoker with short- and long-term memory intact. Resident is an unsupervised smoker. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of smoking safety evaluation dated 04/19/26 revealed the resident does not smoke. Review of smoking safety evaluation dated 05/04/26 revealed the resident does not smoke. Review of list provided by the facility of current smokers revealed Resident #40 was on the list. Interview on 05/19/24 at 9:24 A.M. with MDS Coordinator #163 verified Resident #40 was a smoker and goes out on smoke breaks. MDS Coordinator #163 verified the smoking evaluations completed in April and May 2026 were incorrect. Review of policy titled Smoking Policy-Residents, revised July 2017, revealed a resident's ability to smoke safely will be re-evaluated quarterly, upon significant change and as determined by staff. 4. Review of the medical record for Resident #13 revealed an admission date of 12/07/25. Diagnoses included type two diabetes mellitus, convulsions, hypotension, anemia, transient ischemic attack, hypertension, and alcohol use. Review of the MDS assessment, dated 03/19/26, revealed Resident #13's cognition was moderately impaired. Review of the admission smoking assessment for Resident #13, completed 12/07/25, revealed Resident #13 was not a smoker. Review of the quarterly smoking assessment for Resident #13, completed 03/07/26, revealed Resident #13 was a smoker. Review of Resident #13's smoking assessments revealed there were no smoking assessments completed between 12/07/25 and 03/07/26. Interview on 05/12/26 at 3:30 P.M. with Resident #13 revealed he began smoking in February 2026 and told the Director of Nursing (DON) when he began smoking. Interview on 05/12/26 at 3:37 P.M. LPN #108 stated Resident #13 was not a smoker when he admitted on [DATE]. He began to go outside and smoke a couple of months after his admission. Further interview with LPN #108 revealed she completed Resident #13's smoking assessment on 03/07/26. Interview on 05/12/26 at 3:43 P.M. with the DON and LPN #163 revealed Resident #13 began smoking in February 2026. The DON verified there were no smoking assessments completed between 12/07/25 and 03/07/26. This deficiency represents non-compliance investigated under Complaint Number #1321980.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and facility policy, the facility failed to ensure incontinent residents received timely and effective incontinence care. This affected two (#5, #9) of two residents reviewed for incontinence care and services in a facility census of 65. Findings include: 1.Review of the medical record revealed Resident #5 admitted to the facility on [DATE]. Diagnoses included congestive heart failure, obesity, panic disorder, chronic respiratory failure, venous insufficiency, depression, atrial fibrillation, type 2 diabetes mellitus, generalized edema, hypertension, venous thrombosis and embolism. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 with intact cognition, dependent on staff for the completion of activities of daily living, and always incontinent of bowel and bladder. Review of the Continence Care assessment dated [DATE] revealed Resident #5 was noted with a history of urinary tract infections, incontinent of varying amounts of urine daily using six incontinence briefs every 24 hours. Review of the 05/06/25 plan of care addressed Resident #5's bladder/bowel incontinence related to impaired mobility and physical limitations. Interventions included clean perinium with each incontinence episode, check as needed/required for incontinence, change clothing as needed (PRN) after incontinence episodes, and check the resident, during rounds and as required for incontinence. Review of Visual/Bedside Kardex Report (undated) noted to check resident during rounds and as required for incontinence. The resident's usual performance is dependent with toileting hygiene and not toileted due to mechanical lift transfers. Review of the plan of care response history between 04/12/26 and 05/13/26 noted Resident #5 was recorded as incontinent of urine daily. Interview on 05/11/26 at 10:23 A.M. Resident #5 stated she was not checked or changed every two hours for incontinence. Observation on 05/12/26 at 10:44 A.M. noted Resident #5 was in bed. Resident #5 stated she was last checked for incontinence by Certified Nurse Aide (CNA) #169 at approximately 6:00 A.M. Continued observation and interview on 05/12/26 at 12:57 P.M. revealed Resident #5 was in bed. Resident #5 stated she has not been checked since before breakfast by CNA #169. Resident #5 stated she was currently incontinent.Observation on 05/12/26 at 1:11 P.M. revealed Licensed Practical Nurse (LPN) #18 and CNA #501 entered Resident #5's room. CNA #501 obtained incontinence care supplies and proceeded to remove the front of Resident #5's incontinence brief. CNA#501 cleaned Resident #5;'sperinium and LPN #108 assisted with turning Resident #5 to the left, exposing a heavily soiled brief with urine through to the bed linen and a folded top sheet under the resident. Resident #5's skin area to the buttocks was observed to be red. After CNA #501 cleansed the resident, LPN #108 applied a zinc barrier cream, new brief and folded top sheet under the resident. Interview on 05/12/26 at 1:31 P.M. CNA #501 verified no attempts to check Resident #5 for incontinence had occurred since assuming care of the resident at 7:00 A.M. Interview on 05/12/26 at 1:32 P.M. LPN #108 verified Resident #5 was heavily soiled of urine and was noted with reddened skin to the buttocks caused by urine and associated moisture. 2. Review of the medical record for Resident #9 revealed and admission to the facility on [DATE]. Diagnoses included dementia, transient ischemic attack, cerebral infarction, spinal lumbar stenosis, anxiety disorder, paranoid schizophrenia, major depression, intellectual disability, congestive heart failure, hypertension, and polyarthritis.Review of the Minimum Data Set assessment dated [DATE] revealed Resident #9 with intact cognition and was dependent on staff for the completion of activities of daily living, and always incontinent of bowel and bladder. Review of the 06/21/25 Continence Care Assessment recorded Resident #9 as unable to report when incontinent of urine and utilizing 4-8 adult briefs in 24 hours. Review of the 06/18/24 nursing plan of care addressed Resident #9's activity daily living (ADL) self-care performance deficit related to dementia, paranoid schizophrenia, muscle weakness, major depression, poly arthritis, and myalgia. Resident requires staff assist to complete ADL tasks daily. Interventions included to monitor frequently for incontinence (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of bowel/bladder, no brief at night while in the bed, resident is dependent from one staff member for toilet hygiene, and resident not toileted due to mechanical lift. Review of the 05/06/25 a nursing plan of care addressed Resident #9's bladder/bowel incontinence due to behaviors and dependent on staff for activities of daily living (ADL's). Interventions included the resident uses adult disposable briefs for comfort and dignity, clean peri-area with each incontinence episode, check as needed/required for incontinence, wash, rinse and dry perineum, and change clothing as needed (PRN) after incontinence episodes. Review of Visual/Bedside Kardex Report (undated) under toileting instructed staff to check resident every two hours and assist with toileting as needed. Clean perinium (peri-area) with each incontinence episode. Resident not toileted due to mechanical lift. Observations and interviews on 05/13/26 at 11:25 A.M. noted Activity Aide #146 to propel Resident #9 in his wheelchair to his room. Activity Aide #146 activated the call light and proceeded to exit the room. At 11:26 A.M. CNA #170 and CNA #181 responded to Resident #9's room. CNA #181 stated Resident #9 was requesting to use the toilet. Resident #9 was noted to be incontinent of urine through his pants and onto the mechanical lift sling in the wheelchair. CNA #181 stated she was unaware when Resident #9 was last checked for incontinence. CNA #181 stated staff was unable to transfer the resident to the bathroom due to the size and using the Hoyer lift, therefore Resident #9 was incontinent in an adult brief and is to be checked every two hours. CNA #181 verified Resident #9 was not offered to use the toilet. CNA #181 stated Resident #9 was usually checked after breakfast but unsure of the time. CNA #181 and CNA #170 proceeded to transfer Resident #9 to his bed using the Hoyer lift. The CNAs removed Resident #9's heavily soiled pants, brief and Hoyer lift sling. CNA #181 obtained a basin of water, placed soap to a washcloth and cleansed Resident #9's bilateral groin and lower abdomen skin fold. No attempts were made to cleanse the resident's penis or perinium. CNA #181 proceeded to obtain a clean washcloth and cleanse the same areas. Resident #9 was then positioned to his left side exposing his buttock and a moderate amount of incontinent formed stool. CNA #181 cleansed the stool from Resident #9's buttocks and revealed Resident #9's bilateral inner posterior thighs with reddened skin. CNA #170 summoned LPN #108 to the room and LPN #108 proceeded to apply a zinc barrier cream to the reddened skin. CNA #170 and CNA #181 proceeded to place a new incontinence brief and pants on Resident #9. Interview with CNA #181 and CNA #170 on 05/13/26 at 12:07 P.M. verified Resident #9 was not properly cleansed following an incontinence episode, not provided toileting due to mechanical lift use, and not checked for incontinence every two hours. On 05/13/26 at 12:14 P.M. interview with LPN #108 verified Resident #9 was to be checked and changed for incontinence every two hours. Review of facility policy titled Urinary Incontinence Protocol, revised September 2012, revealed based on assessment of the category and causes of incontinence, the staff will provide scheduled toileting, prompted voiding, or other interventions to try to improve the individuals continence status. Review of facility policy titled Perineal Care, revised October 2010, revealed for a male resident wet washcloth and apply soap or skin cleansing agent. Wash perineal area starting with urethra and working outward. Retract foreskin of the uncircumcised male. Wash and rinse urethral area using circular motion. Continue to wash the perineal area including the penis, scrotum and inner thighs. Do not reuse the same washcloth or water to clean the urethra. Thoroughly rinse the perineal area in the same order, using fresh water and clean washcloth. Gently dry perineum following same sequence. This deficiency represents non-compliance investigated under Complaint Number 2618793.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, and policy review, the facility failed to ensure fluid restrictions identified how much allowed per discipline and shift, failed to document fluid intakes, and failed to obtain daily weights. This affected two (#11 and #76) of two residents reviewed for fluid restrictions. The facility census was 65.Findings include:1.Review of medical record for Resident #11 revealed an admission date of 07/31/23. Diagnoses included polyarthritis, psychosis, hoarding disorder, adjustment disorder with anxiety, anemia, and osteoarthritis.Review of the minimum data set (MDS) assessment dated [DATE] revealed the resident was cognitively intact.Review of care plan dated 03/11/26 revealed the resident has the potential for dehydration or potential fluid deficit and was non-compliant with fluid restrictions. Interventions included limited to 1200 milliliter (ml) fluid restriction per 24 hours. The care plan did not break down the fluids per shift or discipline.Further review of care plan revealed that the resident is at nutritional risk related to cachexia, abnormal weight loss, osteoarthritis, anemia, and hyponatremia. Interventions included to provide and serve regular diet with thin liquids, 1200 ml/day fluid restriction, monitor intake and record every meal, weight per policy, and record. The care plan did not break down the fluids per shift or discipline.Review of current physician orders revealed 1200 ml fluid restriction. The order did not specify how many mls of fluid were to be provided by dietary for each meal and how much nursing was allowed during the 24 period to equal the 1200 ml/day fluid restriction.Review of treatment administration record (TAR) for April 2026 revealed fluid intake was not documented on 7:00 P.M.-7:00 A.M. shift on 04/01/26 and 7:00 A.M.- 7:00 P.M. shift on 04/04/26, 04/05/26, and 04/30/26.Observation and interview on 05/13/26 at 10:43 A.M. revealed the resident was lying in bed. Resident #11 stated he was not really on a fluid restriction. Resident #11 stated he drinks when he is thirsty and when he is not thirsty he does not drink. Observation of the resident's over the bed table revealed two stacks of three Styrofoam cups. One of the cups had a straw and lid. Resident #11 was observed to be short of breath, however the resident states he felt fine.Interview on 05/13/26 at 10:50 A.M. with Registered Nurse (RN #179) revealed Resident #11 was on a fluid restriction. RN #179 verified the physician order did not specify how much dietary provides and how much nursing can provide. RN #179 stated the resident always gets two milks for his meals. RN #179 stated nursing gives the resident approximately 600 mls of fluid daily. RN #179 verified the resident had Styrofoam cups in his room and could get water by himself.Follow up observation on 05/14/26 at 10:44 A.M. revealed the resident lying in bed. Two stacks of three Styrofoam cups were observed on the over bed table as well as several plastic cups.2. Review of medical record for Resident #76 revealed an admission date of 01/24/25 and discharge date of 12/18/25. Diagnoses included coronary artery disease, congestive heart failure, and chronic kidney disease.Review of the MDS assessment dated [DATE] revealed the resident was cognitively intact.Review of physician orders revealed an 1800 ml/day fluid restriction and daily weight. The order did not specify how many mls of fluid were to be provided by dietary for each meal and how much nursing was allowed during the 24 period to equal the 1800 ml/day fluid restriction.Review of care plan dated 01/06/25 revealed the resident had a behavior problem of non-compliant with fluid restrictions. Interventions included administer medications as ordered and intervene as necessary to protect the rights and safety of others.Further review of care plan revealed the resident had potential nutritional problem related to diuretics in place and non-compliant with fluid restrictions. Interventions included but not limited to provide and serve low concentrated sweets mechanical diet with thin liquids: fluid restriction 1800 ml/day, monitor intake and record every meal.Review of TAR for October 2025 revealed daily weight not obtained on 10/30/25. Fluid intake was not documented on day shift 7:00 A.M.-7:00 P.M. on 10/01/25, 10/03/25, 10/07/25, 10/14/25, 10/15/25, 10/22/25, and 10/30/25.Review of TAR for November 2025 revealed daily weight not obtained on 11/0/25, 11/02/25, 11/04/25, 11/11/25, marked NA on 11/13/25, and (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/18/25. Fluid intake was not documented on day shift 7:00 A.M.-7:00 P.M. on 11/01/25, 11/02/25, 11/11/25, 11/12/25, 11/19/25, and 11/20/25.Review of TAR for December 2025 revealed fluid restriction was not documented on day shift 7:00 A.M.-7:00 P.M. on 12/01/25, 12/04/25, 12/08/25-12/10/25, and 12/14/25. Daily weight was not documented on 12/07/25, 12/13/25-12/15/25, and 12/22/25.Interview on 05/19/26 at 9:24 A.M. with MDS #163 verified the physician orders and care plans did not have the fluid restrictions broke down as to how much nursing and dietary could give per day. MDS #163 verified the documentation listed above for Resident #76 was not completed per order.Review of policy titled Encouraging and Restricting Fluids, dated October 2010, revealed the purpose of this procedure is to provide the resident with the amount of fluids necessary to maintain optimum health. Follow specific instructions concerning fluid intake or restrictions, be accurate when recording fluid intake, and record fluid intake on the intake side of the intake and output record and record the fluid intake in mls. When a resident has been placed on restricted fluids, remove the water pitcher and cup from the room. If the resident refuses to have the pitcher removed, notify the supervisor and in turn the physician.This deficiency represents noncompliance investigated under Complaint Number 2667933.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, medical record review, staff interview, and facility policy, the facility failed to ensure medications were administered as prescribed by the physician with an error rate of less than five percent. This affected one (#45) of one resident observed for gastrostomy tube medication administration. A total of 27 medication opportunities with seven errors were observed for an error rate of 25.93 percent. The facility census was 65. Findings include: Observation on 05/12/26 at 7:59 A.M. noted Registered Nurse (RN) #502 preparing Resident #45's medications for administration via the percutaneous endoscopic gastrostomy (PEG)) tube. RN #502 crushed one multivitamin, one glycopyrrolate 1 milligram (mg) tablet, one furosemide 20 mg tablet, one Eliquis 5 mg tablet, one Baclofen 10 mg tablet, and one famotidine 20 mg tablet. RN #502 then placed the medications together (cocktailed) in the same cup with 50 milliliters (ml) of tap water. RN #502 also obtained levetiracetam (Keppra) oral solution 20 ml 100 mg/ml solution and poured to a 30 ml medication cup. At 8:07 A.M. RN #502 entered Resident #45's room with the medications and placed them on the over bed table at the bedside. Inside the room RN #502 obtained a 60 ml piston syringe and an additional 100 ml of tap water inside a piston syringe irrigation set bottle. RN #502 removed the tube feeding solution tubing from the PEG tube and checked a residual which verified placement of the PEG tube. RN #502 poured 30 ml of water into the PEG tube then poured the cocktailed medications into the tube. Observation of the medication cup identified multiple medication residual particulate inside the cup. RN #502 flushed the tube with 30 ml water and then administered the liquid Keppra followed by a flush of 30 ml of water. Observation inside the medication cup noted 10 ml of Keppra remaining in the cup. RN #502 did not attempt to administer the residual medications inside the cocktailed medication cup or the remaining Keppra and discarded the cups to a trash receptacle inside Resident #45's room. Interview on 05/12/26 at 8:19 A.M. RN #502 verified residual medications were inside the medication cups which resulted in Resident #45 not receiving the entire prescribed dose of the medications. Review of Resident #45's medical record revealed current physician orders for all medications to be crushed and administered via PE tube. 03/24/26 Current medication orders included multivitamin adults one oral tablet in morning, glycopyrrolate 1 mg three times a day, furosemide 20 mg two times a day, Eliquis 5 mg two times a day, Baclofen 10 mg three times a day, famotidine 20 mg two times, and levetiracetam oral solution 100mg/ml give 20 ml two times a day. for seizures. There was no physician order indicated medications were to be cocktailed (mixed) together when administering the PEG tube. Review of facility policy titled Administering Medications Through An Enteral Tube, revised March 2015, revealed do not mix medications together prior to administering through an enteral tube. Administer each medication separately. Dilute the crushed or split medication with 15-30 milliliters (ml) room temperature water. Attached 60 ml syringe to feeding tube. Administer medication by gravity flow. Pour medication into the barrel of the syringe while holding the tube slightly above level of insertion. Open the clamp and deliver medication slowly. Clamp tubing before the tubing drains completely. If administering more than one medication, flush with 15 ml room temperature water between medications. When the last medication begins to drain from the tubing., flush the tubing with 15 ml of room temperature water. Quickly clamp the tubing when the flush is complete. Remove syringe. Observations during the total medication administration revealed a total of 27 medication opportunities with seven errors observed for an error rate of 25.93 percent. This deficiency represents noncompliance investigated under Complaint Number 2999106, 2975913, 2589881, 2791151, and 257794.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, and staff interview, the facility failed to ensure resident beds were properly maintained in a safe manner. This affected two (#5, #9) of 20 residents reviewed for safe integrity of beds in a facility census of 65. Findings include:1. Review of the medical record revealed Resident #5 admitted to the facility on [DATE]. Diagnoses included congestive heart failure, obesity, panic disorder, chronic respiratory failure, venous insufficiency, depression, atrial fibrillation, type 2 diabetes mellitus, hypertension, venous thrombosis and embolism. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 with intact cognition. no recorded behaviors and dependent on staff for the completion of activities of daily living including bed mobility. Review of the nursing plan of care dated 01/13/25 addressed activity of daily living (ADL) self-care performance deficit with an intervention including quarter upper bilateral side rails for bed mobility and transfer ability enabler to promote independence. Review of bed system measurement device test results worksheet dated 11/11/25 noted Resident #5's bed to be evaluated for safety and pass. Observation on 05/11/26 at 10:24 A.M. noted Resident #5 in bed. The bed frame was observed extending out from the underside of the mattress with approximately four inches of exposed metal bed frame to the right side of the bed. A gap was noted between the edge of the mattress and the right upper quarter side rail measuring four inches. Observation on 05/12/26 at 1:11 P.M. Licensed Practical Nurse (LPN) #108 and Certified Nurse Aide (CNA) #501 entered Resident #5's room and assisted with turning Resident #5 from side to side. When Resident #5 was turned to the right side her right foot was noted to contact the metal bed frame identified with sharp edges. Interview on 05/12/26 at 1:32 P.M. LPN #108 verified Resident #5 mattress was undersized and exposed the metal bed frame with a gap between the bed rail and edge of the mattress. Observation and interview on 05/12/26 at 1:45 P.M. Maintenance Director #110 measured between the edge of the mattress and edge of bed frame. There was a gap between the mattress and bedframe of six inches at the foot of the bed, four inches middle bed, and three inches between the rail and mattress. Maintenance Director #110 stated he was unaware when Resident #5's bed and mattress were assessed for proper fit. 2. Review of the medical record revealed Resident #9 admitted to the facility on [DATE]. Diagnoses included dementia, transient ischemic attack, cerebral infarction, spinal lumbar stenosis, anxiety disorder, paranoid schizophrenia, major depression, intellectual disability, congestive heart failure, hypertension, Review of the MDS assessment dated [DATE] revealed Resident #9 with intact cognition, psychosis related hallucinations and delusions, range of motion impairment on one side upper and lower extremities, dependent on staff for the completion of activities of daily living including bed mobility and transfer, and experienced two or more falls since admission. Review of the 06/18/24 nursing plan of care addressed Resident #9 had an ADL self-care performance deficit related to dementia, paranoid schizophrenia, muscle spasms, muscle weakness, major depression, polyarthritis, and myalgia. Intervention included upper quarter bilateral side rails for bed mobility and transfer ability as an enabler to promote independence. Review of the physician order on 03/05/26 noted quarter upper bilateral side rails for bed mobility and transfer ability enabler to promote independence. Observation and interview on 05/13/26 at 11:26 A.M. noted CNA #170 and CNA #181 responded to Resident #9's room. Resident #9's bed was equipped with a quarter side rail to the left bed, which was loose, and no quarter side rail was observed to the right side of the bed. CNA #181 verified Resident #9's left bed rail was loose and no bed rail was installed to the right side of the bed. CNA #181 stated Resident #9 used the side rails when being positioned in the bed and was fearful of falling from the bed without them in place. CNA #181 and CNA #170 proceeded to transfer Resident #9 to his bed using the mechanical (Hoyer) lift. The CNA's provided care and transferred Resident #9 back to the wheelchair using the Hoyer lift. Interview with CNA #181 and CNA #170 on 05/13/26 at (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12:07 P.M. verified Resident #9's bed was equipped with a loose bed rail to the left side of the bed and no rail to the right. Observation and interview on 05/14/26 at 6:06 A.M. RN #510 verified Resident #9's left bedrail was loose and the right bed rail was missing. RN #510 stated she was unaware where the missing rail was located. Interview on 05/14/26 at 7:30 A.M. Maintenance Director #110 revealed he was unaware of the loose bed rail and missing bed rail to Resident #9's bed. This deficiency represents non-compliance investigated under Complaint Number 2791151.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, and review of facility policy, the facility failed to maintain a clean, sanitary, and homelike environment. This affected all 65 residents residing in the facility. Findings include: 1.Observation on 05/12/26 at 12:53 P.M. of Resident #42's room revealed the area immediately surrounding the resident's toilet was discolored with a sticky, amber-colored substance, with miscellaneous pieces of black debris adhered to the surface. Further observation of Resident #42's restroom revealed the windowsill was broken and could be lifted off the wall. Additional miscellaneous debris was observed scattered throughout the resident's room floor. Interview on 05/12/26 at 12:53 P.M. with Resident #42 revealed she did not feel the facility did an adequate job of keeping her resident room and restroom clean to her satisfaction. Interview on 05/12/26 at 1:25 P.M. with Certified Nursing Assistant (CNA) #501 verified the sticky, amber-colored substance with miscellaneous pieces of black debris adhered to the surface immediately surrounding Resident #42's toilet, the broken window sill that could be lifted off the wall, and miscellaneous debris scattered throughout the resident's room floor. 2. Observation on 05/18/26 at 7:26 A.M. of the 200-Hallway between Resident #42's room and Resident #28's room revealed multiple areas of an unidentified brown substance on the floor. The first area measured approximately one-quarter inch in height, one-half inch in width, and one inch in length. Approximately one foot away, a second area of the same unidentified brown substance was observed, measuring approximately one-quarter inch in height, one and one-half inches in width, and four inches in length. Roughly two feet from the second area, a third area of unidentified brown substance was observed, similar in shape and size to the second. Approximately one foot beyond the third area, a fourth area of unidentified brown substance was noted, measuring approximately one inch in width and five inches in length. Interview on 05/18/26 at 7:27 A.M. with Registered Nurse (RN) #502 verified the multiple areas of unidentified brown substance on the floor of the 200-Hallway between Resident #42's room and Resident #28's room. Observation on 05/18/26 at 7:36 A.M. of the floor is the 200-Hallway revealed miscellaneous grime and debris by the nursing station and nursing unit hallways. Interview on 05/28/26 at 7:38 A.M. with RN #147 verified the floor of the 200-Hallway by the nursing station and nursing unit hallways contained miscellaneous areas of grime and debris. Observation on 05/18/26 at 7:38 A.M. of the floor in the 300-Hallway revealed an unidentified brown and green substance and miscellaneous grime and debris by the nursing station and miscellaneous grime on the floors of the B wing. Interview on 05/18/26 at 7:40 A.M. with Housekeeping Aide #153 verified the floor in the 300-Hallway contained an unidentified brown and green substance and miscellaneous grime and debris by the (continued on next page)

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	nursing station and miscellaneous grime on the floors of the B wing. Review of the facility policy titled Quality of Life – Homelike Environment, revised May 2017, revealed residents are provided with a safe, clean, comfortable, and homelike environment. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting, including a clean, sanitary, and orderly environment. 3. Observation on 05/11/26 at 10:39 A.M. noted the common shower next room [ROOM NUMBER]. The toilet and floor next to the toilet were covered in a brown substance on the surface. Scattered debris was also identified on the floor including paper and a disposable glove. Observation on 05/11/26 at 12:18 P.M. of the common shower next to room [ROOM NUMBER] revealed the shower stall floor with black substance to the tile floor, orange and brown substance to the base of the wall and floor in the shower, and debris in the sink and on the floor. In addition broken drywall was noted to the base of the wall entering the shower stall. Interview on 05/11/26 12:21 P.M. with Licensed Practical Nurse (LPN) #154 verified the environmental conditions inside both second floor common showers. Interview on 05/18/26 at 12:10 P.M. the Administrator identified 15 residents (#6, #9, #18, #20, #21, #33, #36, #46, #50, #52, #55, #59, #60, #61, #70) residing on the second floor that utilized the common shower rooms. This deficiency represents non-compliance investigated under Complaint Number 2806427, 279115, 2667933, 2618793, 2589881, and 2581692.