STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365456	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Circleville Post-Acute	1155 Atwater Avenue Circleville, OH 43113

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 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 observation, interview, and facility policy review the facility to serve food at a palatable temperature. This affected all 90 residents in the facility. The facility census was 90. Findings include:Observation on 03/10/26 at 11:35 AM during lunch service revealed individually prepared fruit cups sitting on trays in the kitchen. Temperature of the fruit cups was checked by Dietary Manager #426 at 11:48 A.M. and found the temperature of the fruit cups to be 44 degrees Fahrenheit. Dietary Manager placed trays of fruit cups in the freezer.Interview with [NAME] #154 and [NAME] #248 confirmed they did not check the temperature of the fruit cups prior to lunch tray service and stated, we didn't know we had to.Review of the facility's food temperature logs for 02/23/25 through 03/20/26 revealed cold food items temperatures were checked on day of survey after being prompted and on 02/16/26.Observation on 03/10/26 at 12:56 P.M. during the test tray temperature check revealed fruit cup (peaches) temperature at 63 degrees Fahrenheit.Review of the facility's policy titled, Food Receiving and Storage dated 2001 confirmed food shall be received and stored in a manner that complies with safe food handling practices. Further review of the policy confirms Danger Zone means temperatures above 41 degrees Fahrenheit and below 135 degrees Fahrenheit that allow the rapid growth of pathogenic microorganisms that can cause foodborne illness. Potentially hazardous foods (PHF) and time/temperature control for safety (TCS) means food that requires time/temperature control for safety to limit the growth of pathogens. PHF/TCS for safety food means are stored at or below 41 degrees Fahrenheit unless otherwise specified.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and facility policy review the facility failed to store food in a safe manner, store kitchen utensils in a sanitary manner, prepare and serve food in a sanitary manner and maintain an ice machine in a safe and sanitary manner. This affected all 90 residents. The census was 90. Findings include:1.Observation on 03/09/26 at 6:48 AM on shelving near prep table in kitchen revealed a used 32-ounce bottle of kitchen bouquet browning and seasoning sauce (expiration 07/30/25) and 1 gallon of used white wine (expiration 04/14/25). Interview on 03/09/26 at 7:11 AM with [NAME] #154 confirmed expired items on shelving near prep table.Observation on 03/09/26 at 7:04 AM of the dry storage revealed open container of granulated sugar (lid off to the right side) open container of flour (lid off to the right side), 1 gallon of teriyaki marinade and sauce (unopened, expiration date 06/15/25), seven 32 ounce bottles of kitchen bouquet browning and seasoning sauce (unopened, expiration 07/2025), two bottles of 1 gallon red cooking wine (unopened, expiration 06/2025), two bottles of 1 gallon red cooking wine (unopened, expiration 07/14/25), 1 gallon white wine (unopened, expiration 06/16/25) and used 11 lb cream cheese icing (open date noted as 05/15, manufacturer expiration date 11/10/25, hand-written expiration date 12/25/25.Interview on 03/09/26 at 7:05 AM with Dietary Aide #220 confirmed items were expired.Review of the facility's policy titled, Food Receiving and Storage dated 2001 confirmed dry foods are rotated using first in- first out system.2. Observation on 03/09/36 at 7:16 A.M. of the ice machine outside of the kitchen revealed black substance on top part of ice machine and black substance on the right wall of the ice machine right above ice.Interview with Maintenance Director on 03/09/26 at 7:19 AM confirmed the areas of the ice machine were dirty and needed to be cleaned, stated, The company who does the deep clean should be here today.Review of the facility's Ice machine cleaning log revealed the last the clean, sanitize, delime, and filter was completed on 08/20/25, filter was last cleaned on 01/15/25, and the last bin dump/sanitize was completed on 03/01/26.3. Observation of the kitchen on 03/10/26 at 10:41 AM revealed cooking utensils hanging from metal rack attached to ceiling that contained a thick dust coating on metal rack where clean utensils were stored including three pairs of tongs. The metal rack was suspended above the prep table in the kitchen. Further observation revealed a large whisk with dust and spider webs within whisk wires.Interview on 03/10/26 at 10:45 A.M. Dietary Manager #246 confirmed the metal rack holding the utensils was dirty and staff would clean it after lunch service.Observation on 03/10/26 at 12:02 PM revealed [NAME] #154 grabbed a pair of tongs from metal rack on ceiling and use them to handle bread.4. Observation on 03/10/26 at 11:41 AM of lunch tray service revealed [NAME] #154 took eyeglasses off head and wiped them clean with shirt and then proceeded with tray line service without performing hand hygiene.Interview on 03/10/26 at 1:00 PM with [NAME] #154 confirmed they did not perform hand hygiene after touching glasses and shirt.5. Observation on 03/10/26 at 8:35 A.M. of breakfast dining observation in the memory care unit revealed Certified Nursing Aide (CNA) #286 picked up a sausage link from Resident #42's plate with her bare hands, did not perform hand hygiene, or use utensil and hand the sausage link to Resident #42.Observation on 03/10/26 at 8:51 A.M. of breakfast dining observation in the memory care unit revealed CNA #286 dropped a sugar packet on the floor, picked it up and used it to make a resident a coffee.Interview on 03/10/26 at 8:51 A.M. confirmed touched the sausage link with her bare hands and did not perform hand hygiene and confirmed she used sugar packet off of the floor and did not perform hand hygiene.Review of the facility's policy titled, Handwashing/ Hygiene revision date of October 2023, revealed all personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections, to other personnel, residents, and visitors.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on personnel file review, staff interview, and facility policy review, this facility failed to provide a verbal abuse free environment for residents. This affected one resident (#75) of the one resident reviewed for abuse with the potential to affect all 71 residents who received care from Certified Nursing Aide (CNA) #114. The facility census was 90. Findings include:Review of the employee personnel record for Certified Nursing Aide (CNA) #114 revealed multiple corrective action forms including poor customer service, unprofessional behavior including being rude and negative towards residents and coworkers. Review of the Employee Counseling Form dated 09/30/2025 revealed CNA #114 failed to maintain respect for a resident. Review of the Employee Counseling Form dated 10/03/2025 revealed CNA #114 failed to maintain respect of a resident related to poor customer service. Review of a typed statement dated 01/14/2026 provided by Licensed Practical Nurse (LPN) #236 revealed, On 01/13/2026, I had to verbally educate CNA #114 on her tone of voice to a resident in the [NAME] dining room. Reminding her that this is the resident's home and we have to respect it and also if she needed to come talk to me she could do so in my office with the door shut due to residents and family members being around. Review of a typed statement dated 01/19/2026 provided by the Administrator revealed, I received complaints from employees that a resident on [NAME] Unit was upset with the care she was receiving from an CNA. I called into the facility and spoke with the resident (Resident #75) and asked her what was going on. Resident #75 shared that CNA #114 had been mean to her since the day she got here. Resident #75 said when she asked for help, CNA #114 said, If you can't learn to be patient, you will be moved to the bad hall and there are more residents there and it will take even longer for you to get help there. Review of a typed statement dated 01/19/2026 given by Unit Manager #184 revealed, I have personally witnessed CNA #114 displaying rude and unprofessional behavior towards both staff and residents in the last two weeks. CNA #114's conduct has been disrespectful and inappropriate. This staff member has been observed raising her voice in the hallways and discussing residents in a loud manner where others could overhear. For example, she made a statement indicating that a resident refused a shower and commented that the resident stinks and needs to shower. This behavior is not respectful and does not align with expected standards of professionalism or resident dignity. However, at times CNA #114 does provide appropriate care and can be a good caregiver. That being said, the manner in which she speaks at times is inappropriate and unprofessional. Her tone and choice of words do not align with expected standards of respectful communication towards residents and staff. Review of the written statement dated 01/19/2026 and created by LPN #342 revealed, Within the last week or two, I have witnessed CNA #114 being loud and rude to residents and staff on several occasions. Yelling in the halls and at the nurses station. Review of the Performance Improvement Plan (PIP) dated 01/22/2026 for CNA #114 revealed this PIP is being used due to ongoing concerns with poor customer service and unprofessional behavior toward residents and co-worders. These concerns have been observed and reported and are inconsistent with facility expectations, resident rights, and professional conduct standards. Examples include rude, dismissive and disrespectful tone to the residents and staff. Lack of empathy and patience when providing resident care and unprofessional interactions with co-worders, yelling in the hall. Interview on 03/11/2026 at 9:39 A.M. with CNA #114 revealed she had received education multiple times by management staff related to proper customer service and that she had just completed a project improvement plan related to this same thing. Interview on 03/12/2026 at 1:30 P.M. with the Administrator revealed CNA #114 has worked at this facility for a while and everyone loves her. The Administrator revealed that on 03/24/2024 a Self-Reported Incident (SRI) was completed due to a resident reporting concern with her clothing and not getting a shower. On 09/30/2025 a resident reported that they felt CNA #114 was rushing care. On 10/03/2025 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	a resident claimed she was upset after CNA #114 was talking to her about her diet order. When asked what was said, the Administrator claimed she did not know. The Administrator claimed that she receives word that Resident #75 was upset over CNA #114, so she called and spoke with the resident later that evening and asked her if she felt like it was abuse and she said not but it was just poor customer services so that was why a SRI was not completed. Interview on 03/12/2026 at 2:21 P.M. with the Director of Nursing (DON) revealed CNA #114 used to work on a unit called Main Street but is no longer allowed to work this unit due to not being allowed to care for a resident who currently resides on that unit. The DON claims that she personally does not have issues with CNA #114 but other staff members do especially when they request this staff member to complete a task that she does not want to do; she will become rude and disrespectful. Review of the facility policy titled, Abuse, Neglect, exploitation or Misappropriation-Reporting and Investigation, dated 09/2022 revealed If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The administrator or individual making the allegation immediately reports his or her suspicion to the following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the facility. This deficiency represents non-compliance investigated under Complaint Number 2726246.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on personnel file review, self-reported incident review, staff interview, and facility policy review, this facility failed to report verbal abuse to the required state agency. This affected one resident (#75) of the one resident reviewed for abuse with the potential to affect all 71 residents who received care from Certified Nursing Aide (CNA) #114. The facility census was 90. Findings include:Review of the employee record for Certified Nursing Assistant (CNA) #114 revealed multiple corrective action forms including poor customer service, unprofessional behavior including being rude and negative towards residents and coworkers. Review of the Employee Counseling Form dated 09/30/2025 revealed CNA #114 failed to maintain respect for residents. Review of the Employee Counseling Form dated 10/03/2025 revealed CNA #114 failed to maintain respect of residents related to poor customer service. Review of a typed statement dated 01/14/2026 provided by Licensed Practical Nurse (LPN) #236 revealed, On 01/13/2026, I had to verbally educate CNA #114 on her tone of voice to a resident in the [NAME] dining room. Reminding her that this is the resident's home and we have to respect it and also if she needed to come talk to me she could do so in my office with the door shut due to residents and family members being around. Review of a typed statement dated 01/19/2026 provided by the Administrator revealed, I received complaints from employees that a resident on [NAME] unit was upset with the care she was receiving form an CNA. I called into the facility and spoke with the resident (Resident #75) and asked her what was going on. Resident #75 shared that CNA #114 had been mean to her since the day she got here. Resident #75 said when she asked for help, CNA #114 said, If you can't learn to be patient, you will be moved to the bad hall and there are more residents there and it will take even longer for you to get help there. Review of a typed statement dated 01/19/2026 given by Unit Manager #184 revealed, I have personally witnessed CNA #114 displaying rude and unprofessional behavior towards both staff and residents in the last two weeks. CNA #144's conduct has been disrespectful and inappropriate. This staff member has been observed raising her voice in the hallways and discussing residents in a loud manner where others could overhear. For example, she made a statement indicating that a resident refused a shower and commented that the resident stinks and needs to shower. This behavior is not respectful and does not align with expected standards of professionalism or resident dignity. However, at times CNA #114 does provide appropriate care and can bed be a good caregiver. That being said, the manner in which she speaks at times is inappropriate and unprofessional. Her tone and choice of words do not align with expected standards of respectful communication towards residents and staff. Review of the hand written statement dated 01/19/2026 and created by LPN #342 revealed, Within the last week or two, I have witnessed CNA #114 being loud and rude to residents and staff on several occasions. Yelling in the halls and at the nurses station. Review of the Performance Improvement Plan (PIP) dated 01/22/2026 for CNA #114 revealed this PIP is being used due to ongoing concerns with poor customer service and unprofessional behavior toward residents and co-worders. These concerns have been observed and reported and are inconsistent with facility expectations, resident rights, and professional conduct standards. Examples include rude, dismissive and disrespectful tone to the residents and staff. Lack of empathy and patience when providing resident care and unprofessional interactions with co-worders, yelling in the hall. Review of the facility's Self-Reported Incidents revealed no SRI had been created or submitted for this incident where Resident #75 verbalized she was upset over the way CNA #114 had spoken to her and treated her. Interview on 03/12/2026 at 1:30 P.M. with the Administrator revealed CNA #114 has worked at this facility for a while and everyone loves her. The Administrator revealed that on 03/24/2024 a Self-Reported Incident (SRI) was completed due to a resident reporting concern with her clothing and not getting a shower. On 09/30/2025 a resident reported that they felt CNA #114 was rushing care. On 10/03/2025 a resident claimed she was upset (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	after CNA #114 was talking to her about her diet order. When asked what was said, the Administrator claimed she did not know. The Administrator claimed that she received word that Resident #75 was upset over CNA #114, so she called and spoke with the resident later that evening and asked her if she felt like it was abuse and she said no but it was just poor customer services so that was why a SRI was not completed. Interview on 03/12/2026 at 2:21 P.M. with the Director of Nursing (DON) revealed CNA #114 used to work on a unit called Main Street but was no longer allowed to work this unit due to not being allowed to care for a resident who currently resides on that unit. The DON claimed that she personally does not have issues with CNA #114 but other staff members do especially when they request this staff member to complete a task that she does not want to do; she will become rude and disrespectful. Review of the facility policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigation, dated 09/2022 revealed If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The administrator or individual making the allegation immediately reports his or her suspicion to the following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the facility.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on personnel file review, self-reported incident review, staff interview, and facility policy review, this facility failed to thoroughly investigate an allegation of verbal abuse. This affected one resident (#75) of the one resident reviewed for abuse with the potential to affect all 71 residents who received care from Certified Nursing Aide (CNA) #114. The facility census was 90. Findings include: Review of the employee record for Certified Nursing Assistant (CNA) #114 revealed multiple corrective action forms including poor customer service, unprofessional behavior including being rude and negative towards residents and coworkers. Review of the Employee Counseling Form dated 09/30/2025 revealed CNA #114 failed to maintain respect for residents. Review of the Employee Counseling Form dated 10/03/2025 revealed CNA #114 failed to maintain respect of residents related to poor customer service. Review of a typed statement dated 01/14/2026 provided by Licensed Practical Nurse (LPN) #236 revealed, On 01/13/2026, I had to verbally educate CNA #114 on her tone of voice to a resident in the [NAME] dining room. Reminding her that this is the resident's home and we have to respect it and also if she needed to come talk to me she could do so in my office with the door shut due to residents and family members being around. Review of a typed statement dated 01/19/2026 provided by the Administrator revealed, I received complaints from employees that a resident on [NAME] unit was upset with the care she was receiving form an CNA. I called into the facility and spoke with the resident (Resident #75) and asked her what was going on. Resident #75 shared that CNA #114 had been mean to her since the day she got here. Resident #75 said when she asked for help, CNA #114 said, If you can't learn to be patient, you will be moved to the bad hall and there are more residents there and it will take even longer for you to get help there. Review of a typed statement dated 01/19/2026 given by Unit Manager #184 revealed, I have personally witnessed CNA #114 displaying rude and unprofessional behavior towards both staff and residents in the last two weeks. CNA #144's conduct has been disrespectful and inappropriate. This staff member has been observed raising her voice in the hallways and discussing residents in a loud manner where others could overhear. For example, she made a statement indicating that a resident refused a shower and commented that the resident stinks and needs to shower. This behavior is not respectful and does not align with expected standards of professionalism or resident dignity. However, at times CNA #114 does provide appropriate care and can bed be a good caregiver. That being said, the manner in which she speaks at times is inappropriate and unprofessional. Her tone and choice of words do not align with expected standards of respectful communication towards residents and staff. Review of the hand written statement dated 01/19/2026 and created by LPN #342 revealed, Within the last week or two, I have witnessed CNA #114 being loud and rude to residents and staff on several occasions. Yelling in the halls and at the nurses station. Review of the Performance Improvement Plan (PIP) dated 01/22/2026 for CNA #114 revealed this PIP is being used due to ongoing concerns with poor customer service and unprofessional behavior toward residents and co-worders. These concerns have been observed and reported and are inconsistent with facility expectations, resident rights, and professional conduct standards. Examples include rude, dismissive and disrespectful tone to the residents and staff. Lack of empathy and patience when providing resident care and unprofessional interactions with co-worders, yelling in the hall. Review of the facility's Self-Reported Incidents (SRI) revealed no SRI had been created or submitted for this incident where Resident #75 verbalized she was upset over the way CNA #114 had spoken to her and treated her. Interview on 03/12/2026 at 1:30 P.M. with the Administrator revealed CNA #114 has worked at this facility for a while and everyone loves her. The Administrator revealed that on 03/24/2024 a Self-Reported Incident (SRI) was completed due to a resident reporting concern with her clothing and not getting a shower. On 09/30/2025 a resident reported that they felt CNA #114 was rushing care. On 10/03/2025 a resident claimed she was upset after CNA #114 was talking to her about her diet order. When asked what was said, the Administrator (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	claimed she did not know. The Administrator claimed that she receives word that Resident #75 was upset over CNA #114, so she called and spoke with the resident later that evening and asked her if she felt like it was abuse and she said not but it was just poor customer services so that was why a SRI was not completed. Interview on 03/12/2026 at 2:21 P.M. with the Director of Nursing (DON) revealed CNA #114 used to work on a unit called Main Street but was no longer allowed to work this unit due to not being allowed to care for a resident who currently resides on that unit. The DON claimed that she personally does not have issues with CNA #114 but other staff members do especially when they request this staff member to complete a task that she does not want to do; she will become rude and disrespectful. Review of the facility policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigation, dated 09/2022 revealed If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The administrator or individual making the allegation immediately reports his or her suspicion to the following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the facility. Continued reviewed revealed, The individual conducting the investigation as a minimum, reviews the documentation and evidence, reviews the resident's medical record to determine the residents physical and cognitive stats at the time of the incident and since incident, interviews the resident's roommate, family members and visitors, interviews other residents to whom the accused employee provides care or services.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and facility record review the facility failed to prepare puree diet to the proper texture. This affected eight residents (#1, #3, #9, #24, #25, #44, #83, and #87) the facility identified as receiving a pureed diet. The census was 90. Findings include:Observation on 03/10/26 at 10:47 AM of lunch tray service revealed the chipped beef and country gravy puree was started. Further observation on 10:51 A.M. with [NAME] #154 revealed [NAME] #154 pouring pureed food into a metal container for service. [NAME] #154 did not taste the puree to check the texture, larger pieces of chipped beef were observed.Interview on 03/10/26 at 10:51 A.M. with [NAME] #154 revealed [NAME] #154 stated, I can go more but that's all the meat pieces will go down. [NAME] #154 did not taste puree to check the texture.Observation on 03/10/26 at 10:51 A.M. with Dietary Manager #426 advised [NAME] #154 to puree the chipped beef and gravy longer. Further observation at 10:56 A.M. revealed a smoother texture.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to implement an antibiotic stewardship program that included ensuring appropriate antibiotic use. This affected four residents (#59, #68, #69, and #83) of five residents reviewed for antibiotic use. The facility census was 90. Findings include: 1. Review of the record for Resident #68 revealed an admission date of 01/24/26 and diagnoses including dementia, chronic kidney disease, and hypertension. A Minimum Data Set (MDS) assessment completed 01/31/26 documented a brief interview for mental status (BIMS) score of 7, severe cognitive impairment. It indicated the resident was continent of urine and occasionally incontinent of bowel. Review of nursing progress notes dated 03/05/26 at 5:38 P.M. revealed the resident was agitated and tearful today. Obtained urine order. Review of a nursing progress note dated 03/11/26 at 2:26 P.M. revealed urine culture results this shift. Physician notified of results and continued altered mental status. New order received for Amoxicillin (antibiotic) 500 milligrams three times daily for three days due to resident receiving prophylactic Amoxicillin today for pre-op dental procedure. New order to begin 03/12/26. Review of a nursing progress note dated 03/11/26 at 3:34 P.M. revealed growth 20,000-25,000 cfu/ml of Escherichia coli. Growth is under criteria. Resident only presents with symptoms of behavior this time. Physician aware. Resident will continue on antibiotics per order. Review of the urine culture results for Resident #68 revealed on 03/11/26 she had 20-25,000 CFU/ml of Escherichia Coli in her urine. Amoxicillin was not listed on the culture results as an antibiotic the bacteria was sensitive to. Review of an infection screening evaluation completed 03/12/26 revealed it indicated the resident was afebrile, had no pain, and had no symptoms of infection marked. Under infection analysis, it did not indicate the infection met the Loebs or McGeers criteria for urinary infection. There was no evidence the physician documented the reason for ordering an antibiotic for a resident with only a symptom of altered mental status and a urine culture that did not show >100,000 bacteria. Interview with Licensed Practical Nurse (LPN) Unit Manager #184 on 03/12/26 at 2:30 P.M. confirmed Resident #68's urine culture did not show >100,000 bacteria and her only symptom was altered mental status. She confirmed Amoxicillin was continued on 03/12/26 for the urinary tract infection as the resident had already received it as a one time dose for a dental appointment prior. She confirmed Amoxicillin was not listed on the urine culture as an antibiotic the bacteria was sensitive to. Interview with the Director of Nursing on 03/12/26 at 3:20 P.M. revealed it is at the physician's discretion to order antibiotics when it does not meet the criteria for an infection. She stated they go over it with the physician that it does not meet criteria but the physician does not document the rationale for continuing to order an antibiotic. Interview with Medical Director #424 on 03/12/26 at 4:20 P.M. revealed he orders antibiotics on a case by case basis. He stated Resident #68 had called 911 multiple times. He confirmed the antibiotic ordered was not listed on the culture results but stated it was similar to another antibiotic on the list. He did not provide any reasoning for not using an antibiotic listed on the culture results that indicated (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	the bacteria was sensitive to it and did not justify using an antibiotic when the only symptom exhibited was altered mental status. 2. Review of the record for Resident #59 revealed an admission date of 02/03/21 and diagnoses including diabetes, lymphedema, morbid obesity, and hypertension. Review of a MDS assessment completed 01/15/26 revealed a BIMS score of 15, intact cognition. It further stated he was continent of bowel and bladder. Review of a nursing progress note dated 01/20/26 at 9:57 P.M. revealed a new order was obtained from the physician to obtain a urine sample for complaints of flank pain and burning with urination. Review of a nursing progress note on 01/24/26 at 2:05 P.M. revealed new lab results for urine culture sent to physician. New order for Cefdinir (antibiotic) 300 milligrams twice daily for seven days. Review of urine culture results for Resident #59 dated 01/24/26 revealed 26-30,000 CFU/ml of Proteus Mirabilis bacteria. The urine culture results did not list Cefdinir as an antibiotic the bacteria was sensitive to. Review of a nursing progress note dated 01/25/26 at 9:11 A.M. revealed culture with growth of 26-30,000 Proteus Mirabilis. Growth under criteria. Only presents with dysuria. Physician aware. Continue antibiotics. Review of an infection screening evaluation dated 01/24/26 revealed Resident #59 was afebrile, had acute dysuria, and had no other symptoms of infection. There was no evidence the physician documented the reason for ordering an antibiotic for a resident with only a symptom of dysuria and a urine culture that did not show >100,000 bacteria. Interview with Licensed Practical Nurse (LPN) Unit Manager #184 on 03/12/26 at 2:30 P.M. confirmed Resident #59's urine culture did not show >100,000 bacteria. She confirmed the antibiotic Cefdinir was not listed on the culture as an antibiotic the bacteria was sensitive to. Interview with the Director of Nursing on 03/12/26 at 3:20 P.M. revealed it is at the physician's discretion to order antibiotics when it does not meet the criteria for an infection. She stated they go over it with the physician that it does not meet criteria but the physician does not document the rationale for continuing to order an antibiotic. Interview with Medical Director #424 on 03/12/26 at 4:20 P.M. revealed he orders antibiotics on a case by case basis. He stated there were no antibiotics listed on the urine culture that were not administered by intravenous route. Therefore, he ordered an antibiotic not on the urine culture that could be given orally. He confirmed Resident #59 had a low CFU of bacteria in the urine but he chose to treat even though it did not meet the criteria of an infection. 3. Review of the record for Resident #83 revealed an admission date of 10/18/22 and diagnoses including cerebral infarction, diabetes, and chronic obstructive pulmonary disease. Review of an MDS assessment completed 01/10/26 revealed a BIMS score of 1, severe cognitive impairment. It noted the resident was always incontinent of bowel and bladder. Review of a nursing progress note dated 02/12/26 at 7:03 P.M. revealed the resident was noted to have increased pain and dysuria. Physician notified. In house urine dip performed and placed in tubes. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Urinalysis and culture added to lab. Review of urine culture results dated 02/21/26 revealed >100,000 CFU/ml of Klebsiella Ozaenae. Review of a nursing progress note dated 02/21/26 at 5:06 P.M. revealed a new order was obtained for Keflex (antibiotic) 500 milligrams three times daily for seven days. Review of the urine culture results from 02/21/26 revealed Keflex was not listed on the sensitivity report as being an antibiotic the bacteria was sensitive to. There were nine other antibiotics listed on the urine culture that the bacteria was sensitive to. Interview with Licensed Practical Nurse (LPN) Unit Manager #184 on 03/12/26 at 2:30 P.M. confirmed Keflex was not listed on the urine culture as an antibiotic the bacteria was sensitive to. Interview with the Director of Nursing on 03/12/26 at 3:20 P.M. revealed it is at the physician's discretion to order antibiotics. She stated they go over the results with the physician but the physician does not document the rationale for ordering an antibiotic. Interview with Medical Director #424 on 03/12/26 at 4:20 P.M. revealed he felt Keflex and Cefazolin (listed on the urine culture as sensitive) were interchangeable. Review of the medication administration record for February 2026 revealed the resident received Keflex 500 milligrams three times daily from 02/21/26 to 02/28/26 for a total of 21 doses. 4. Review of Resident #69's medical record revealed an admission date of 03/14/25. Diagnoses included senile degeneration of brain, dementia in other diseases classified elsewhere unspecified severity with agitation, cerebrovascular disease, chronic obstructive pulmonary disease, personal history of urinary tract infections, acquired absence of right leg above knee, essential (primary) hypertension, and bilateral hearing loss. Review of Resident # 69's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 00. Review of Resident #69's functional abilities revealed Resident #69 was dependent on care for toileting hygiene. Review of Resident #69's bladder and bowel section confirmed Resident #69 was always incontinent of urine and had an ileostomy in place. Review of Resident #69's active diagnoses confirmed Resident #69 did not have a urinary tract infection noted within the last 30 days. Review of Resident #69's Minimum Data Set (MDS) dated [DATE] review of Resident #69's active diagnoses confirmed Resident #69 did not have a urinary tract infection noted within the last 30 days. Review of Resident #69's care plan dated 02/24/26 revealed Resident #69 has bladder incontinence and was at risk for complications. Goals included minimize risk for skin breakdown to the extent possible through end of life care and will maintain comfort and dignity through end-of-life care. Interventions included complete bowel and bladder assessment per facility policy to assess for changes in continence, observe/document and notify physician of complications of incontinence of signs of urinary tract infection such as fever, dysuria, hematuria, and foul-smelling urine, offer toileting on rounds, and provide incontinence care on rounds, upon request and as needed. Review of Resident #69's progress notes revealed note dated 02/24/26 at 12:16 P.M. stated, new (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	orders received per hospice to discontinue obtaining a urine specimen at this time. The hospice nurse reported she will discuss initiating a low-dose prophylactic antibiotic with the physician. Resident and responsible party were notified and are aware. Further review of progress notes revealed a note dated 02/24/26 at 12:42 P.M. revealed a note stating, new orders per hospice, Macrobid oral capsule 100 MG, give 1 tablet by mouth at bedtime for prophylaxis resident and responsible party aware. Further review of Resident #69's progress notes dated 03/09/26 at 12:58 P.M. revealed a note stating, since the resident was discharged from hospice a request was made by the family to continue Macrobid prophylactically, The MD has been made aware and agrees with plan. Review of Resident #69's physician orders confirmed an order for Macrobid Oral Capsule 100 MG (Nitrofurantoin Monohyd Macro) give 1 capsule by mouth at bedtime for prophylaxis which started on 02/24/26. Review of Resident #69's Medication Administration Record (MAR) confirmed Resident #69 started on Macrobid Oral Capsule 100 MG on 02/24/26. Interview on 03/12/26 at 2:15 PM with the Director of Nursing (DON) agreed there was no valid indication for the use of ordered Macrobid. Interview on 03/12/26 at 2:56 P.M. with the DON stated she spoke with the Medical Director and he stated Resident #69's order for Macrobid is appropriate given her history of urinary tract infections. Review of the facility's policy titled, Antibiotic Stewardship, dated 12/2016, revealed antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents. Orientation, training, and education staff will emphasize the importance of antibiotic stewardship and will include how inappropriate use of antibiotics affects individual residents and the overall community.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, interview, and facility policy review, the facility failed to ensure Resident #69 was free from physical restraints. This affected one resident (#69) of one resident reviewed for physical restraints. The census was 90. Findings include:Review of Resident #69's medical record revealed an admission date of 03/14/25. Diagnoses included senile degeneration of brain, dementia in other diseases classified elsewhere unspecified severity with agitation, cerebrovascular disease, chronic obstructive pulmonary disease, personal history of urinary tract infections, acquired absence of right leg above knee, essential (primary) hypertension, and bilateral hearing loss.Review of Resident # 69's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 00. Review of Resident #69's functional abilities revealed Resident #69 is dependent on care for toileting hygiene, rolling left to right, sit to lying, chair/bed-to-chair transfer and uses a manual wheelchair. Review of Resident #69's bladder and bowel section confirmed Resident #69 was always incontinent of urine and has an ileostomy in place.Review of Resident #69's care plan dated 03/18/25 revised on 11/10/25 revealed Resident #69 was at risk for falls with or without injury noting Resident #69 lays at opposite end of bed at times, Resident #69 purposefully places self on floor at times, Resident #69 with dementia and staff unable to educate and encouragement provided with safety measures in place. Goals included Resident #69 will not experience injuries placing self on floor, Resident #69 will not experience any negative outcomes related to laying at opposite end of bed through next review date and will minimize risk for falls to extent possible through end of life care, and will not have any major injuries related to fall. Interventions included urinary toileting program task: toileting in anticipation of needs after meals and at bedtime, staff to assist resident up, out of bed before breakfast per resident preference, anticipate and meet needs, dycem to the top of the cushion to wheelchair seat for safety, body pillow to the left side of bed while in bed for safety initiated 10/16/25, encourage resident to lay at correct end of bed, keep call light within reach, monitor for changes in condition affecting risk for falls and notify physician if observed, provide proper, well-maintained footwear as indicated, and provide verbal reminders/cues to ask for assistance as needed.Review of Resident #69's physician order entered 10/16/25 revealed an order for a body pillow to left side of bed while in bed for safety every day and night shift.Review of Resident #69's 10/16/25 un-witnessed fall investigation report revealed Resident #69 was found sitting on floor beside her bed on her floor mat. IDT note revealed Resident #69 appears to have slid out of her bed, and she stated she does not recall what she was doing prior to landing on the floor. New order for body pillow to left side of bed while in bed due to poor safety awareness, resident, responsible party, hospice, MD aware and all parties agree with updated plan of care. IDT agrees with plan of care.Observation on 03/09/26 at 8:30 A.M. of Resident #69 revealed Resident #69 lying in bed on right side of body with body pillow to left edge of bed, fall mat on floor near bedside.Observation on 03/09/26 at 10:54 A.M. of Resident #69 revealed Resident #69 lying in bed on right side of body pillow to left edge of bed that is tightly tucked under fitted sheet with fall mat on floor near bedside.Observation on 03/09/26 at 11:06 A.M. of Resident #69 revealed Resident #69 laying in bed with body pillow to left edge of bed that is tucked under fitted sheet with fall mat on floor near bedside.Interview on 03/09/26 at 11:06 A.M. with Certified Nurse Aide (CNA) #286 confirmed the body pillow was in place to prevent Resident #69 from scooting herself out of bed. CNA #286 stated the resident scooted herself out of bed a few months but hasn't done it again.Interview on 03/12/26 at 8:40 with Registered Nurse (RN) #140 confirmed Resident #69 body pillow was placed due to a fall.Interview on 03/12/26 at 4:59 P.M. with Medication Aide (MA) #278 stated Resident #69 could remove the body pillow if needed to but when asked to have Resident #69 demonstrate ability to remove said body pillow, MA #278 confirmed Resident #69 could not remove the pillow on (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	command.Review of the facility's policy titled, Use of Restraints dated 04/2017 revealed restraints shall only be used to treat the resident's medical symptom (s) and never for discipline or staff convenience, or for the prevention of falls. Further review of the policy revealed the definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove the device in the same manner in which the staff applied it given that resident's physical condition and this restricts his/her typical ability to change position or place, that device is considered a restraint.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, medical record review, policy review, and staff interview, the facility failed to ensure a resident receiving psychotropic medication was being adequately monitored for response to treatment. This affected one resident (#3) of five residents reviewed for unnecessary medications. The facility census was 90.Findings include:Review of the medical record for Resident #3 revealed an admission date of 01/02/26 and diagnoses including Parkinson's induced psychosis with a history of visual and auditory hallucinations, history of paranoia, and Parkinson's disease with dyskinesia (involuntary and uncontrollable body movements). He was admitted [DATE] with an order for an antipsychotic medication (Pimavanserin 34 milligrams daily) which is used to treat hallucinations and delusions associated with Parkinson's disease psychosis. A Minimum Data Set (MDS) assessment completed 01/09/26 documented a brief interview for mental status score of 11, indicating moderately impaired cognition. The MDS further stated the resident was dependent for eating, toileting, dressing, hygiene, bed mobility, and transfers. He was incontinent of bowel and bladder. It documented that no behaviors were exhibited. Observations on 03/11/26 at 11:55 A.M. and 12:20 P.M. revealed Resident #3 to be up in a wheelchair in the dining room for lunch. He was being fed lunch by a staff person. He had his eyes closed during the meal but did respond verbally when asked a question. Observations on 03/11/26 at 12:55 P.M. revealed Resident #3 to be up in a wheelchair in his room. He had his eyes closed but responded verbally to his name but did not open his eyes. When asked if he felt sleepy, he responded no. He did not reply when asked why he keeps his eyes closed alot. He was also noted to have constant movements of his tongue and mouth. Review of psychiatric progress notes on 02/02/26 revealed he was seen for medication management. He recently transferred from another facility to be closer to family. He easily engages today and reports his mood is good. He has a history of visual and auditory hallucinations and paranoia. Nursing staff report no observed signs or symptoms of psychosis. Per the notes, there had been no change in movement disorder since 12/11/25 (prior to admission). The note indicated he had been on Pimavanserin since 01/25/24. Recommendations included ongoing symptom monitoring. Review of nursing progress notes dated 02/10/26 at 2:32 P.M. revealed the aide reported the resident having decreased appetite and being more lethargic. The physician was notified and reviewed the resident's medication. Flexaril (muscle relaxant) was discontinued. Review of a physician progress note on 02/13/26 documented Resident #3 was being seen for a routine follow up. Has been a little bit confused and out of it over the last couple days per staff. His urine was dipped yesterday and was negative. He seems pretty sleepy today. Vitals are stable. Laboratory testing was ordered for the next lab day. Review of weight records revealed Resident #3's weight had gone from 226.4 pounds on 01/02/26 to 217.2 pounds on 02/01/26 to 212 pounds on 03/02/26 (14.4 pound weight loss in two months). Review of a nutritional progress note dated 03/03/26 at 1:15 P.M. revealed he had lost 6.1 percent in two months since admission. He was on a pureed diet and was eating 51-100% of most meals. A recommendation for a liquid nutritional supplement (Glucerna 8 ounces daily) was made for nutritional support. A physician's order was obtained on 03/03/26 for Glucerna 8 ounces daily due to weight loss. Interview with Certified Nurse Aide (CNA) #302 on 03/11/26 at 9:55 A.M. and with Registered Nurse #140 on 03/11/26 at 1:00 P.M. revealed Resident #3 sleeps off and on throughout the day but not excessively. They both confirmed he does not have any behaviors and his level of assistance with activities of daily living and his involuntary movements have not changed since admission. There was no evidence the facility was monitoring/tracking for any behaviors related to the Parkinson's induced psychosis. Interview with Physician #424 on 03/11/26 at 7:53 A.M. revealed he was not aware of any other issues with Resident #3 since his note on 02/13/26 regarding the resident being sleepy. Interview with Director of Nursing #284 on 03/11/26 at 2:00 P.M. confirmed the facility had no behavior tracking (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in place to monitor for any targeted behaviors related to the use of the antipsychotic medication for Resident #3. Interview with Psychiatric Nurse Practitioner #376 on 03/12/26 at 8:32 A.M. revealed she had provided care for Resident #3 at the previous facility for two years. She confirmed he had a history of Parkinson's induced psychosis with visual hallucinations. She stated he was previously on two antipsychotics but one had been discontinued prior to admission to the facility. She stated he had always had the tardive dyskinesia. She confirmed that he does sit with his eyes closed but did not feel it was due to sedation. She was not aware of the weight loss experienced in two months. She confirmed staff should be monitoring for targeted behaviors, including hallucinations. Review of the facility policy titled Psychotropic Medication Use dated 2001 revealed residents receiving psychotropic medication are monitored and the response to treatment is documented. Monitoring may include behavior flow sheets.

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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 medical record reviews, observations, and interviews, the facility failed to notify the physician regarding blood pressure, weight changes and failed to follow physician recommendations for insulin for Resident #92. This affected three residents (#02, #91, #92) out of three residents reviewed for quality of care. The census was 90. Findings include: 1. Review of the closed medical record for Resident #92 revealed the resident was admitted to facility on 06/15/21. Diagnoses included cerebral infarction (CI), type two diabetes mellitus, hyperglycemia, hemiplegia and hemiparesis following CI affecting right dominant side, major depressive disorder, anxiety and history of falls. Review of Resident #92's physician orders dated 01/14/26 revealed Medical Director (MD) #424 ordered Basaglar KwikPen Subcutaneous Solution Pen-injector 100 units per milliliter (ml) (Insulin Glargine) with instructions to inject 25 unit subcutaneously at bedtime (HS) for type two diabetes and Humalog 100 unit/ml (Insulin Lispro) with instructions to inject three times daily as per sliding scale: if 150 - 200 milligrams per deciliter (mg/dL) = 2 units; 251 - 300 mg/dL = 6 units; 301 - 350 mg/dL = 6 units; 351 - 400 mg/dL = 8 units; 401 - 450 mg/dL = 10 units. It stated if above 450 mg/dL, notify the MD. Both of the orders were discontinued on 01/19/26. Review of the nurses notes dated 01/19/26 revealed a verbal order given by MD #424 was taken by Licensed Practical Nurse (LPN) #384 including new orders to discontinue current Basaglar and Humalog doses and change to Basaglar 35 units at HS and Humalog give 5 units before meals and at HS, and hold if blood sugar was less than 120 mg/dL. The resident and her responsible party were aware. Review of Resident #92's physician orders dated 01/19/26 revealed an order for Basaglar KwikPen Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Glargine) with instructions to inject 35 unit subcutaneously at bedtime for type two diabetes and Humalog Kwikpen 100 unit/ml with instructions to give 5 units subcutaneously before meals and at HS, and hold if blood sugar was less than 120 mg/dL. There were no new orders for sliding scale insulin. Review of Resident #92's physician progress notes dated 01/19/26 revealed an order to increase Basaglar Insulin from 25 units up to 35 units and to add Humalog 5 units before every meal along with a sliding scale insulin and it noted that they could revisit things in about a week. Review of Resident #92's medication administration record (MAR) for January 2026 revealed the resident received the Basaglar and Humalog medications as ordered from 01/19/26 through 01/30/26. The MAR further revealed the resident was not receiving any sliding scale insulin. Interview on 03/11/26 at 10:44 A.M. with Director of Nursing (DON) revealed after review of the progress notes and medication order regarding the sliding scale, the nurse documented the verbal order and if sliding scale was not ordered by the physician, she did not document it in verbal order. Interview on 03/11/26 at 11:27 A.M. with the DON confirmed Resident #92's sliding scale order was documented in the progress note by MD #424 on 01/19/26, but was not carried forward with the new insulin orders. Interview on 03/12/26 at 7:50 A.M. with MD #424 revealed if it was in his progress notes that he wanted Resident #92 on sliding scale, then he expected her to be on sliding scale. He stated it would (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have been a verbal order that he gave to staff. 2. Review of the medical record for Resident #2 revealed an admission date of 08/06/25. Diagnoses included Parkinson's disease, vascular dementia, chronic heart failure, above the knee amputation of the right leg and below the knee amputation of the left leg, diabetes, malnutrition and dysphagia. Review of the plan of care dated 08/08/25 revealed Resident #2 was at risk for impaired cardiac function with interventions to observe for weight gain and take weights as ordered. Review of physician orders for 12/19/25 for daily weights due to congestive heart failure with instructions to notify the Physician of weight gains or losses of three pounds in one day or five pounds in one week. Review of the Medication Administration Record (MAR) dated 01/2026 revealed a weight gain of 6.4 pounds (lbs) from 01/01/26 to 01/08/26, 6.8lbs from 01/02/26 to 01/09/26, six lbs from 01/03/26 to 01/10/26, five lbs from 01/04/26 to 01/11/26, and a weight loss of 5.2 lbs from 01/24/26 to 01/31/26. Review of the Medication Administration Record (MAR) dated 02/2026 revealed daily weight gain of 3.4lbs from 02/01/26 to 02/02/26, a gain of 6.6lbs from 02/05/26 to 02/06/26, a gain of 4.4lbs from 02/08/26 to 02/09/26, and a weight gain of 8.6 from 02/27/26 to 02/28/26. The MAR also identified a seven day weight loss of seven lbs from 01/25/26 to 02/01/26, a gain of 6.4lbs from 01/30/26 to 02/06/26, a gain of 5.2lbs from 02/01/26 to 02/08/26, a gain of 6.2lbs from 02/02/26 to 02/09/26, and a weight gain of seven lbs from 02/21/26 to 02/28/26. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 was cognitively intact with a BIMS of 15. Review of the Medication Administration Record (MAR) dated 03/2026 revealed a weight gain of 8.8lbs from 02/22/26 to 03/01/26, a gain of 7.6lbs from 02/25/26 to 03/04/26, a gain of nine lbs from 02/26/26 to 03/05/26, and a gain of 9.2lbs from 02/27/26 to 03/06/26. Review progress notes dated 01/01/2026 to 03/10/26 revealed no mentions of facility staff informing the physician of three pound weight changes in one day or five pound weight changes in one week. A note dated 01/05/26 stated the physician was informed of weight change with no new orders, but chart review found no weight changes within the ordered parameters was identified on 01/05/26. Review of weights and vitals from 01/01/26 to 03/10/26 reveled a daily weight change of a weight loss of 5.6lbs from 01/26/26 to 01/27/26 then a second weight on 01/27/26 revealed a gain of three lbs, a weight gain of 3.4 lbs from 01/28/26 to 01/29/26, a loss of 3.4lbs from 01/31/26 to 02/01/26, a weight gain of 3.4 from 02/01/26 to 02/02/26, a weight gain of 6.6 lbs from 02/05/26 to 02/06/26, a weight loss of five lbs from 02/06/26 to 02/07/26 and a second weight on 02/07/26 with a weight gain of 3.4 lbs, a weight gain of 4.4lbs from 02/08/26 to 02/09/26, a weight gain of 8.6lbs from 02/27/26 to 02/28/26. Weekly weight changes included a weight gain of 6.4lbs from 01/01/26 to 01/08/26, a weight gain of 6.8lbs from 01/02/26 to 01/09/26, a weight gain of six lbs from 01/03/26 to 01/10/26, a weight gain of five lbs from 01/04/26 to 01/11/26, a weight loss of 5.2 lbs from 01/24/26 to 01/31/26, a weight loss of seven pounds (lbs) from 01/25/26 to 02/01/26, a weight gain of five lbs from 01/27/26 to 02/03/26, a gain of 6.4lbs from 01/30/26 to 02/06/26, a gain of 5.2lbs from 02/01/26 to 02/08/26, a gain of 6.2lbs from 02/02/26 to 02/09/26, and a weight gain of seven (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Circleville Post-Acute	1155 Atwater Avenue Circleville, OH 43113

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lbs from 02/21/26 to 02/28/26, a weight gain of 8.8 pounds (lbs) from 02/22/26 to 03/01/26, a gain of 7.5lbs from 02/24/26 to 03/03/26, a gain of 7.6lbs from 02/25/26 to 03/04/26, a gain of nine lbs from 02/26/26 to 03/05/26, and a gain of 9.2 lbs from 02/27/26 to 03/06/26. Review of the medical record found that between the documented weights in the MAR's and the weights/vitals sections, notifications were to be done for weight changes on 01/08/26, 01/09/26, 01/10/26, 01/11/26, 01/27/26, 01/29/26, 01/31/26, 02/01/26, 02/02/26, 02/03/26, 02/06/26, 02/07/26, 02/08/26, 02/09/26, 02/28/26, 03/01/26, 03/03/26, 03/04/26, 03/05/26, and 03/06/26. Interview on 03/10/26 at 2:20 P.M. with Director of Nursing (DON) confirmed Resident #2's weights were documented in both the MAR and the weights and vitals section of the medical record and confirmed the weights varied and on most days two to three weights were obtained. She confirmed weight changes should be communicated to the Physician as ordered. She confirmed several daily weight changes of three or more pounds in a day or five or more pounds in a week occurred without documentation of physician notification. Interview on 03/10/26 at 3:55 with the Assistant Director of Nursing (ADON) #236 confirmed many weight notifications were missed. She provided only evidence of notifications for weight refusals. 3.Review of Resident #91's medical record revealed an admission date of 01/28/26. Diagnoses include unspecified sequelae of cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, chronic respiratory failure with hypoxia, unspecified atrial fibrillation, atherosclerotic heart disease of native coronary artery without angina pectoris, and essential (primary) hypertension. Review of Resident #91's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13. Review of Resident #91's active diagnoses included hypertension. Review of Resident #91's care plan dated 02/02/26 revealed Resident #91 was at risk for impaired cardiac function and complications related to active smoker, atherosclerotic heart disease, atrial fibrillation, coronary artery disease (CAD), history of myocardial infarction, hyperlipidemia, Hypertension (HTN), LBBB, Resident expected to fluctuate. Goal included Resident #91 will have no signs of cardiac distress. Interventions included administer medications as ordered. Observe, document, and notify MD of adverse side effects, cardiology consultation/follow-up as indicated, diet as ordered, elevate legs as resident will allow, labs per order and notify physician of results, notify physician of signs of cardia distress such as chest pain, irregular heart rate, fainting, chest pain, dizziness and decreased activity tolerance, obtain vitals signs as indicated, and weights as ordered. Review of Resident #91's progress notes dated 02/11/26 at 6:43 A.M. noted Resident #91 had high blood pressure this morning, MD notified and advised to give morning lisinopril and metoprolol and recheck in one hour. Resident blood pressure noted as 201/92 on 02/11/26 at 6:41 A.M. Blood pressure recheck was completed on 02/11/26 at 8:45 A.M. revealed blood pressure of 188/73 with a progress note timestamped at 8:44 A.M. this nurse checked blood pressure after morning medication administration 188/73, MD and responsible party aware, no new orders, no concerns voiced. Review of Resident #91's blood pressure revealed Resident #91's blood pressure on 02/12/26 found to be 177/99, and on 02/13/26 was found to be 193/81. Resident #91's blood pressure on 02/14/26 was found to be 214/126. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/12/26 at 7:52 A.M. with Medical Director (MD) #424 revealed he was not aware of Resident #91's blood pressure continued elevation and stated regarding Resident #91's blood pressure because it was the weekend and I was probably notified with notes in my box. Interview on 03/12/26 with 2:45 P.M. with Regional Nurse confirmed the facility was still looking for the blood pressure notes left for Medical Director #424 regarding Resident #91's elevated blood pressure. No notes were received from the facility regarding notification of Resident #91's blood pressure to MD. Review of the facility's policy titled, Blood Pressure/ Measuring, dated 09/2010, confirms hypertension is defined as blood pressure over 140/90 mm/Hg (although the elderly often have persistent systolic readings from 140 to 160 mm/Hg. Further review of the policy reveals, hypertension should be reported to the physician. If a resident has a hypertensive reading, staff should record several readings taken at different times of the day. Staff should note any pertinent medications and/or recent changes of condition when reporting to the physician.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review the facility failed to properly monitor Resident #42 with a history of exit seeking and wandering. This affected one resident (#42) of one resident reviewed for elopement. The census was 90. Findings include:Review of Resident #42's medical record revealed an admission date of 08/07/23. Diagnoses included Alzheimer's disease, dementia in other diseases classified elsewhere unspecified severity with other behavioral disturbance, restlessness and agitation, essential (primary) hypertension, atherosclerotic heart disease of native coronary artery without angina pectoris, major depressive disorder and insomnia.Review of Resident #42's care plan dated 08/08/23 and revised on 11/12/24 revealed Resident #42 was at risk for elopement/exit seeking related to dementia, Alzheimer's disease, wanders, oblivious to safety needs noting Resident #42 was on memory care unit. Goals included the resident's safety will not be endangered related to behaviors and resident will not leave the facility without a responsible person with a target date noted as 01/23/26. Interventions included allow wandering in safe areas within the facility, approach in a calm, nonthreatening manner, assess for pain and/or discomfort and medicate as needed, check door alarms promptly to ensure safety, ensure all exit doors are secured and functioning to their maximum capacity, document and notify physician if behavior interferes with daily functioning, elopement risk assessment per facility, keep photograph in risk for elopement binder, monitor for anticipation of increased exit seeking behaviors such as pacing, redirect and intervene as indicated, provide redirection as needed, an visual cue outside of residents door to remind resident of location. No elopement care plan updates noted since 10/24/25.Review of Resident #42's Elopement and Wandering Risk Observation/assessment dated [DATE] revealed Resident #42 exhibits unsafe wandering or elopement attempts but is easily redirected with a score of 24. Review of Resident #42 completed Elopement and Wandering Risk Observation/Assessments revealed no new assessment was completed on 03/06/26 or after.Review of Resident #42's Minimum Data Set (MDS) dated [DATE] for Brief Interview for Mental Status (BIMS) score of 00. Review of Resident #42's functional abilities revealed Resident #42 required partial/moderate assistance with roll left to right, lying to sitting on side of bed, chair/bed-to-chair transfer, and tub/shower transfer. Resident #42 required supervision or touch assistance with sitting to lying, sit to stand, toilet transfer, walk 50 feet with two turns and walk 150 feet.Review of Resident #42's physician orders reveal an order to encourage resident to remain in common area with staff when out of room dated 11/23/25, and staff to redirect resident when seen wandering dated 09/11/24.Review of the facility's incident/accident log confirmed an incident occurred on 03/06/26 noting other (specify in notes).Review of Resident #42's progress notes revealed there was no documentation of an incident that occurred on 03/06/26.Interview on 03/12/26 at 11:40 A.M. confirmed Resident #42 left the memory care unit alone (on 03/06/26) without Certified Nurse Aide (CNA) #188 in sight.Review of Resident #42's concern form dated 03/06/26 confirmed Resident #42 did leave memory care unit without CNA #188 as they stated they were providing care to another resident and unable to check the sounding alarm. CNA #188 did not promptly attend to the door alarm or complete a head count. Statement from Licensed Practical Nurse (LPN) #430 confirmed CNA #188 was given verbal education to immediately attend an alarm sounding and do a head count.Review of Resident #42's facility investigation for incident on 03/06/26 confirmed Resident #42 resides on a secured memory care unit with alarmed doors as the primary environmental safety intervention, stating at the time of the incident, Resident #42 was observed to be exit-seeking, pushing on the memory care door until it opened, triggering the door alarm.Observation on 03/09/2026 at 8:19 A.M revealed Resident #42 trying to open the memory care unit door with alarm sounding before Resident #42 was redirected to her room.Interview on 03/12/26 at 1:35 P.M. with Administrator confirmed Resident #42's incident on (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	03/06/26 the report was not complete since the CNA had not come into the facility to provide a statement in person and confirmed there were no progress notes regarding the incident in Resident #42's medical record.Review of the facility's policy titled, Wandering and Elopements, dated 2001 confirmed if an employee observes a resident leaving the premises, they should attempt to prevent the resident from leaving in a courteous manner, get help from other staff members in the immediate vicinity, instruct another staff member to inform the charge nurse or director of nursing services that a resident is attempting to leave or has left the premises. When the resident returns to the facility, the director of nursing services or chare nurse shall, examine the resident for injuries, contact the attending physician and report findings, notify the resident's legal representative (sponsor), completed and file an incident report, and document relevant information in the resident's medical record.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, and staff interview, the facility failed to ensure resident's blood pressure was measured or obtained per physician orders including not being obtained in the left arm where an arteriovenous shunt/fistula, used for dialysis treatments was located. This affected one resident (#9) of the one resident reviewed for dialysis services. The facility census was 90. Findings include:Review of the medical record for Resident #9 revealed an initial admission date of 10/29/2021 and a re-entry date of 01/14/2022. Diagnoses included end stage renal disease, dependence on renal dialysis, and heart failure. Review of Resident #9's Significant Change Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 06 out of 15 indicating this resident experienced a severely impaired cognition for daily decision-making abilities. Resident #9 was noted to receive renal dialysis services. Review of the plan of care dated 12/27/21 and revised 01/21/26 revealed Resident #9 required dialysis services related to end stage renal failure and was at risk for complications such as fluid overload. Resident #9 also had an AV fistula to the left arm and was at risk for impaired circulation and clotting. Interventions for this care plan included to monitor fistula to the left arm and no blood pressure or lab draws in the left arm. Review of current orders for Resident #9 included to not use the left arm for blood pressure, intravenous treatments or blood draws due to it being the location for the AV fistula. Review of Resident #9's blood pressure log from 01/02/2026 through 03/11/2026 revealed this resident's blood pressure was obtained using the left arm 58 times. Interview on 03/12/2026 at 9:47 A.M. with Licensed Practical Nurses (LPN) #134 and #384 revealed that at the start of the shift, the nurse will make a list of residents who need vital signs taken and give that list to the Certified Nursing Assistants (CNA). After obtaining these vital signs, the CNA will return the list to the nurse. If there are any abnormal reading, they will highlight that reading and verbally tell the nurse. When blood pressures are obtained, the CNAs don't normally indicate which arm is used. If there is a resident who is leaving for dialysis services, the resident's nurse will obtain their vital signs to document in the electronic charting system and to document on the Dialysis communication form. The nurse will also obtain the same residents vital sings upon return to the facility from Dialysis treatments. LPN #134 verified there was multiple incidents where Resident #9 had his blood pressure checked by using the left arm which was where the AV shunt was located and blood pressures were not to be obtained with this arm.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and policy review, facility failed to ensure pharmacy recommendations were acknowledged by the physician and addressed in a timely and medically appropriate manner for two residents (#2 and #76). This affected two residents (#2, #76) of five residents reviewed for unnecessary medications. Facility census was 90.Findings include1. Review of the medical record for Resident #2 revealed an admission date of 08/06/25. Diagnoses included Parkinson's disease, vascular dementia, chronic heart failure, above the knee amputation of the right leg and below the knee amputation of the left leg, diabetes, malnutrition and dysphagia. Review of the pharmacy recommendation dated 08/31/25 revealed a recommendation per hospital discharge summary uploaded, allergy to zinc is listed. Please clarify if zinc should be added to allergy list in point click care, (electronic medical record). The recommendation form was acknowledged by the physician on 09/02/25 and marked completed by a facility nurse on 09/02/25. Review of the medical record found no documentation from the Physician clarifying the allergy discrepancy from the recommendation dated 08/31/25. Review of the pharmacy recommendation dated 09/28/25 revealed a recommendation per hospital discharge summary uploaded, allergy to zinc is listed. Please clarify if zinc should be added to allergy list in point click care, (electronic medical record). The recommendation form was not acknowledged or signed by the physician. On 09/29/25 the recommendation was acknowledged by a facility nurse with a notation, Resident does not currently have an allergy to zinc. Review of the medical record found no documentation from the Physician clarifying the allergy discrepancy from the recommendation dated 09/28/25. Review of the pharmacy recommendation dated 11/29/25 revealed a recommendation Resident is ordered a Multivitamin-minerals oral tablet (multiple vitamins with minerals) with instructions to give one tablet by mouth once daily. Zinc is listed on allergy list. Please clarify if any changes are appropriate. The recommendation form was acknowledged by the physician with an eligible date appearing to be 12/31 and acknowledged by a facility nurse on 12/04/25. The allergy was circled and the note d/c allergy (discharge) was written on the pharmacy recommendation. Review of the medical record found no documentation from the Physician clarifying the allergy discrepancy from the recommendation dated 11/29/25. Review of the pharmacy recommendation dated 12/31/25 revealed a recommendation Resident is ordered Epoetin Alfa Injection Solution 10000 unit/ml with instructions to inject one milliliter subcutaneously once daily every Friday for hemoglobin less than 10 and hold if hemoglobin greater than 10. Per the AVS (after visit summary) uploaded 12/18/25, the dose is listed differently. Please review the AVS and clarify if dose should be changed. The recommendation form was acknowledged by the physician on 01/07/26 who wrote OK on the recommendation. Review of the AVS dated 12/18/25 from the hospital admission revealed a medication order for epoetin alfa 2,000 units/ml injection with instructions to inject one ml (2,000 Units total) under the skin once weekly on Friday and give if hemoglobin less than 10 and hold if greater than 10 for anemia. Review of the medical record found no documentation from the Physician clarifying the dosing discrepancy between the after visit summary (AVS) and what was ordered at the facility and what was indicated on the recommendation dated 12/31/25. Review of lab result dated 01/21/26 revealed a hemoglobin result of 10.6. Review of the MAR dated 01/2026 revealed the medication Epoetin Alfa Injection Solution was administered on 01/23/26. Review of the pharmacy recommendation dated 01/29/26 revealed a recommendation Resident is ordered Epoetin Alfa Injection Solution 10000 unit/ml with instructions to inject one milliliter subcutaneously once daily every Friday for hemoglobin less than 10 and hold if hemoglobin greater than 10. Lab results on 01/21/26 showed hemoglobin of 10.6 with reference range of 14 to 18. Per the Medication Administration Record (MAR) report a dose was administered on 01/23/26. Please evaluate if any changes are appropriate and educate nursing on administration (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	parameters. The recommendation form was acknowledged by the physician on 01/30/26 who wrote OK on the recommendation. Review of lab result dated 01/28/26 revealed a hemoglobin result of 11.0. Review of the MAR dated 01/2026 revealed the medication Epoetin Alfa Injection Solution was administered on 01/30/26. Review of the medical record found no documentation from the Physician following the pharmacy recommendation findings. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 was cognitively intact with a BIMS of 15. Interview on 03/11/26 at 4:00 P.M. with the Director of Nursing (DON) confirmed the staff member signing the pharmacy recommendations was a unit manager (Licensed Practical Nurse LPN #184) and confirmed she was not a Physician, Physician assistant or a nurse practitioner. The DON confirmed the recommendation dated 08/31/25 did not address the concern related to a possible allergy discrepancy, the recommendation dated 09/28/25 was not signed or acknowledged by the Physician, and the recommendation dated 11/29/25 did not have anything documented in the medical record that the allergy was clarified and found to not be an allergy. The DON also confirmed the recommendation dated 12/31/25 was marked as ok regarding a dosing discrepancy but confirmed the order stayed the same with no documentation or reasoning from the Physician why there was a difference and confirming the accurate dosing. The DON confirmed the recommendation on 01/29/26 was related to staff administering the medication outside the parameters and confirmed facility had no documentation this was looked into as medication errors and no documentation of staff education being provided. The DON confirmed Medical Director #424 signed with his first initial K and confirmed several of the dates are not legible. She acknowledged it cannot be proven these recommendations were looked into timely as the dates are unknown for several and no documentation was made in the medical record related to the concerns and no changes were documented (IE: Orders being changed). Interview on 03/12/26 at 8:15 AM with Medical Director #424 revealed the pharmacy recommendations should be provided in a timely manner for review and would not speak to why a nurse was filling them out and signing off they were done. 2. Review of the medical record for Resident #76 revealed an admission date of 01/31/24. Diagnoses included chronic respiratory failure, vascular disease, heart failure, emphysema, liver disease and muscle weakness. Review of physician orders dated 01/27/25 to 12/01/25 for Magnesium Oxide tablet 400mg with instructions to give one tab by mouth twice daily. Review of physician order dated 03/03/25 to 06/18/25 revealed an order for Colace oral capsule with instructions to give one capsule by mouth twice daily. Review of the pharmacy recommendation dated 03/17/25 revealed a recommendation elevated potassium of 5.5 with reference range 3.5 to 5.3 and low magnesium of 1.7 with reference range of 1.9 to 2.7 with recommendations to evaluate if labs needed to be completed sooner than the scheduled lab on 03/26/25. The recommendation form was acknowledged by a nurse on 03/19/25 and stated labs would be done tomorrow on 03/19/25. The Physician did not sign or acknowledge review of the pharmacy recommendation. Review of the medical record found no evidence the Physician was informed of the recommendation on 03/17/25 and acknowledged the report. Review of lab results dated 03/19/25 revealed a magnesium level of 1.7 with a reference range from 1.9 to 2.7. Review of the pharmacy recommendation dated 04/14/25 revealed a recommendation low magnesium of 1.5 with reference range of 1.9 to 2.7 with recommendations to evaluate if magnesium supplement should be increased. The recommendation form was acknowledged by the Physician on 04/16/25 and stated continue 400mg twice daily and monitor labs with scheduled labs. Review of lab results dated 04/23/25 revealed a magnesium level of 1.6 with a reference range from 1.9 to 2.7. Review of lab results dated 04/29/25 revealed a magnesium level of 1.8 with a reference range from 1.9 to 2.7. Review of a physician order dated 05/18/25 to 12/17/25 revealed an order for lidocaine external patch 4% with instructions to apply to left forearm topically every 12 hours as needed for pain. Review of lab results dated 05/28/25 revealed a magnesium level of 1.7 with a reference range from 1.9 to 2.7. Review of the pharmacy recommendation dated 05/31/25 revealed a recommendation resident is ordered Lidocaine External Patch 4% with instructions to apply every 12 hours as needed (PRN) for (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain with a recommendation to consider changing the PRN scheduled to daily PRN of on for 12 hours and off for 12 hours. The Physician documented on the form stating change lidocaine patch order to daily PRN. A second recommendation stated resident is ordered Colace oral capsule (docusate sodium) with instructions to give one capsule by mouth twice daily for constipation with a recommendation to clarify strength. The Physician documented give Colace 100 twice daily for constipation. The Physician acknowledged the form on 06/09/25 and the nurse signed on 06/18/25 indicating recommendations were put in place. Review of physician order dated 06/18/25 to 12/17/25 revealed an order for Colace oral capsule with instructions to give 100mg capsule by mouth twice daily. Review of lab results dated 06/25/25 revealed a magnesium level of 1.8 with a reference range from 1.9 to 2.7. Review of the pharmacy recommendation dated 10/28/25 revealed a recommendation resident is ordered Magnesium oxide tablet 400mg with instructions to give one tablet by mouth twice daily with lab result on 10/23/25 of 1.3 with reference range of 1.9 to 2.7 with a recommendation to clarify if the magnesium supplement should be increased. The form was acknowledged by the DON on 10/28/25 with a note verbal order no recommendations at this time and was initialed by the DON. The form was not signed or acknowledged by the Physician. Review of the medical record found no evidence the Physician was informed of the recommendation on 10/28/25 and acknowledged the report and no changes were made to orders until 12/01/25 and 12/02/25. Review of lab results dated 11/28/25 revealed a magnesium level of 1.6 with a reference range from 1.9 to 2.7. Review of physician order dated 12/01/25 to 12/17/25 for Magnesium Oxide oral tablet with instructions to give 600mg by mouth. Review of physician order dated 12/02/25 to 12/17/25 for Magnesium Oxide oral tablet 400mg with instructions to give one tablet by mouth. Review of lab results dated 12/04/25 revealed a vitamin D level of 10 with a reference range from 30 to 100. Review of lab results dated 12/15/25 revealed a magnesium level of 1.8 with a reference range from 1.9 to 2.7. Review of physician order dated 01/02/26 for Magnesium Oxide oral tablet 400mg with instructions to give by mouth. Review of physician order dated 01/02/26 revealed an order for Cholecalciferol tablet 1000 unit once daily for supplement. Review of lab results dated 01/05/26 revealed a magnesium level of 1.6 with a reference range from 1.9 to 2.7. Review of the pharmacy recommendation dated 01/31/26 revealed a recommendation lab result on 01/05/26 for magnesium level of 1.6 with reference range of 1.9 to 2.7. Resident is ordered Magnesium oxide tablet 400mg with instructions to give one tablet by mouth once daily with a recommendation to consider rechecking the magnesium level. The form was acknowledged by the Physician with an eligible date and was marked, OK. Review of lab results dated 02/02/26 revealed a magnesium level of 1.7 with a reference range from 1.9 to 2.7. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #76 was cognitively intact with a BIMS of 15. Review of the pharmacy recommendation dated 02/24/26 revealed a recommendation Resident is ordered Vitamin D oral tablet (Cholecalciferol) with instructions to give 10000mcg by mouth once a day. The recommendation requested to clarify the dose in directions was supposed to be 10,000 units and was acknowledged by the Physician and marked yes. The date marked was eligible. Review of lab results dated 03/02/26 revealed a magnesium level of 1.5 with a reference range from 1.9 to 2.7. Interview on 03/12/26 at 2:30 P.M. with the DON confirmed the staff member signing the pharmacy recommendations was a unit manager (Licensed Practical Nurse LPN #184) or herself and confirmed she was not a Physician, Physician assistant or a nurse practitioner. The DON confirmed the recommendations dated 03/17/25 and 10/28/25 had no acknowledgement or evidence they were reviewed by the Physician. The DON confirmed the recommendation dated 03/17/25, 04/14/25, 10/25/25, and 01/31/26 in relation to law magnesium levels and the pharmacy recommendations to follow up on labs and consider adjustments in medications. The DON confirmed the resident was consistently below the reference range and confirmed the medical record contained no Physician documentation related to resident having consistently low magnesium. The DON acknowledged the lidocaine order was never changed per Physician response to the 05/31/25 pharmacy report and also confirmed the Colace order was not changed for nine days after the (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician signed the Pharmacy report. The DON confirmed Medical Director #424 signed with his first initial K and confirmed several of the dates are not legible. Interview on 03/12/26 at 8:15 AM with Medical Director #424 revealed the pharmacy recommendations should be provided in a timely manner for review and would not speak to why a nurse was filling them out and signing off they were done. Interview on 03/12/26 around 4:00 P.M. with the Administrator revealed the facility had no additional information to show compliance and acknowledged issues with documentation related to pharmacy recommendations. Review of facility policy titled Medication Regimen Reviews (MRR) dated 02/2025 revealed the MRR shall include a review of the medical record to prevent, identify, report and resolve medication related problems or errors. The pharmacist shall provide a written copy of pharmacy report of any irregularities and upon receipt the Attending Physician reviews and responds to the report. The Physician shall document in the Resident's medical record that the pharmacy recommendations have been reviewed and what actions (if any) they are taking to address them. If they do not provide a timely response, the Consultant Pharmacist shall contact the Medical Director and if they are the Physician the Administrator shall be contacted.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure one resident was free from unnecessary medication when facility administered medications outside of parameters. This affected one resident (#2) of five residents reviewed for unnecessary medications. Facility census was 90. Findings include Review of the medical record for Resident #2 revealed an admission date of 08/06/25. Diagnoses included Parkinson's disease, vascular dementia, chronic heart failure, above the knee amputation of the right leg and below the knee amputation of the left leg, diabetes, malnutrition and dysphagia. Review of the physician orders dated 12/19/25 for Epoetin Alfa Injection Solution 10000 unit/ml with instructions to inject one milliliter subcutaneously once daily every Friday for hemoglobin less than 10 and hold if hemoglobin greater than 10. Review of lab result dated 12/31/25 revealed a hemoglobin result of 10.0. Review of the medication administration record (MAR) dated 01/20/26 revealed the medication Epoetin Alfa Injection Solution was administered on 01/02/26. Review of lab result dated 01/21/26 revealed a hemoglobin result of 10.6. Review of the MAR dated 01/2026 revealed the medication Epoetin Alfa Injection Solution was administered on 01/23/26. Review of lab result dated 01/28/26 revealed a hemoglobin result of 11.0. Review of the pharmacy recommendation dated 01/29/26 revealed a recommendation Resident is ordered Epoetin Alfa Injection Solution 10000 unit/ml with instructions to inject one milliliter subcutaneously once daily every Friday for hemoglobin less than 10 and hold if hemoglobin greater than 10. Lab results on 01/21/26 showed hemoglobin of 10/6 with reference range of 14 to 18. Per the Medication Administration Record (MAR) report a dose was administered on 01/23/26. Please evaluate if any changes are appropriate and educate nursing on administration parameters. The recommendation form was acknowledged by the physician on 01/30/26 who wrote OK on the recommendation. Review of the MAR dated 01/2026 revealed the medication Epoetin Alfa Injection Solution was administered on 01/30/26. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 was cognitively intact with a BIMS of 15. Interview on 03/11/26 at 4:00 P.M. with the Director of Nursing (DON) confirmed the recommendation on 01/29/26 was related to staff administering the medication outside the parameters. The DON verified the order did not give instructions for staff what to do for a hemoglobin of 10.0 but just included results for over and under. The DON also confirmed Epoetin Alfa Injection Solution was administered on 01/02/26 without specific orders and on 01/23/26 for a hemoglobin level of 10.6 and 01/30/26 for a hemoglobin of 11.0. The DON confirmed a result of 10.6 and 11.0 should have indicated for staff to hold the medication and not administer it.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observations, staff interviews, and facility policy review, the facility failed to maintain contact precautions for residents' with diagnosis of Clostridioides difficile (c-diff) as well as failed to provide proper catheter care. This affected two residents (#66 and #29) of five residents reviewed for infection control. Findings include: 1. Review of the medical record for Resident #29 revealed an admission date of 01/27/2026. Diagnosis included enterocolitis due to Clostridioides difficile, Methicillin resistant Staphylococcus Aureus infection and chronic pain. Review of Resident #29's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 indicating an intact cognition for daily decision-making abilities. Resident #29 was noted to experience impairment to bilateral lower extremities and required the use of a mechanical (Hoyer) lift and wheelchair for transfers and mobility. Resident #29 was dependent on staff for toileting and personal hygiene and required an indwelling catheter for urine elimination and was always incontinent of bowel function. Review of the nursing progress note dated 02/12/26 at 3:51 P.M. created by Licensed Practical Nurse (LPN) #384 revealed, Received results for C-diff, resulted positive. Physician notified and gave order to start Fidaxomicin (an antibiotic) 200 milligrams (mg) twice a day for 10 days. Review of the nursing progress note dated 02/23/26 at 1:25 P.M. created by LPN #240 revealed, Physician in house rounding this date. New order to discontinue Mucinex and consult a Gastroenterologist (GI) specialist due to C.Diff infection. Review of the nursing progress note dated 02/24/26 at 8:24 A.M. created by Unit Manager #184 revealed, This nurse contacted the Physician regarding Resident #29's continued soft stools while completing antibiotic therapy. Physician advised, No diarrhea, no treatment indicated. This nurse will continue to monitor the resident closely for any changes in symptoms or condition. The resident currently has a gastroenterology consult in place related to a previous C. difficile infection. However, the order has been updated to reflect referral to GI for evaluation of persistent loose stools. Review of the nursing progress note dated 02/27/26 at 5:16 P.M. created by LPN #240 revealed, Physician in to see Resident #29 this afternoon. Resident continues with heavy diarrhea related to C-diff. Physician gave order to start Fidaxomicin 200 mg twice a day for 5 days and start probiotic for gut health. Observation completed on 03/09/2026 at 8:12 A.M. and again on 03/11/2026 at 9:41 A.M. revealed Resident #29 was up in a wheelchair sitting in the dining room located on the [NAME] unit where there were multiple other residents noted as well for mealtime. Interview on 03/12/2026 at 11:45 A.M. with Certified Nursing Assistant (CNA) #114 revealed she has worked here for about 10 years, and she verified that Resident #29 is having frequent incontinent episode of a small amount of liquid stool or diarrhea. CNA #114 identified staff will wash Resident #29 upon getting her out of bed for mealtime and she also has hand sanitizer that she uses before coming out of her room. CNA #114 claimed she was not sure how often the Hoyer lift which is used to get Resident #29 out of bed is cleaned but this equipment is used on other residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/12/2026 at 10:30 A.M. with Unit Manager #184 who is also the facility's infection preventionist revealed Resident #29 was admitted to this facility with a order for intravenous antibiotics from the hospital. Resident #29 started to experience diarrhea or loose stools and tested positive for c-diff. Since c-diff is contained and is spread through feces to mouth contact, this resident is permitted to leave her room for meals. Interview on 03/12/2026 at 1:30 P.M. with the Administrator revealed per her understanding, they cannot force a resident to stay in their room, and it is their right to come out. When asked if the isolation information was relayed to the resident so they could decide to stay in their room or not, the Administrator identified she was not sure and this surveyor informed the Administrator this was not documented in the medical record and the Administrator said, oh it's not. Review of Center for Disease Control (CDC) guidelines for C.difficile in long-term care (LTC) focus on immediate contact precautions, rigorous environmental cleaning with bleach, and strict hand hygiene using soap and water. Residents with suspected or confirmed CDI should be isolated, ideally in a private room, until diarrhea resolves, typically at least 48 hours. Key CDC Recommendations for LTC Facilities: -Isolation and Precautions: Place symptomatic residents (those with diarrhea) on Contact Precautions immediately, even before lab confirmation. Contact precautions (gloves and gowns) should continue for at least 48 hours after the last episode of diarrhea. -Hand Hygiene: Soap and water are mandatory. Alcohol-based hand sanitizers are ineffective against C. diff spores. -Environmental Cleaning: Use an EPA-registered, spore-killing disinfectant (e.g., sodium hypochlorite/bleach) for daily cleaning of the patient environment, particularly high-touch surfaces like toilets, bed rails, and door handles. -Resident Management: If possible, dedicate equipment (blood pressure cuffs, thermometers) to the infected resident. Limit the movement of infected residents outside their rooms. -Antibiotic Stewardship: Implement programs to ensure appropriate antibiotic use, as unnecessary antibiotics are the primary risk factor for C. diff. -Staff Education: Educate staff, residents, and visitors about transmission prevention and proper Personal Protective Equipment (PPE). 2. Review of the medical record for Resident #66 revealed an admission date of 04/25/25 and diagnoses including cerebral infarction, hemiplegia, diabetes, morbid obesity, obstructive uropathy, retention of urine, and chronic kidney disease. A Minimum Data Set assessment completed 01/23/26 documented a brief interview for mental status score of 15, intact cognition. It stated the resident was always incontinent and had no catheter. Review of physician's orders revealed an indwelling catheter was inserted on 03/06/26 due to obstructive uropathy. The resident had a physician's order 03/06/26 for catheter care every shift. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed the resident had physician's orders for antibiotics for urinary tract infections on 12/25/25 for 10 days (Cipro), on 02/21/26 for seven days (Cipro), and on 03/07/26 intravenous antibiotics (Ertapenem sodium) were ordered for seven days due to Extended-spectrum beta-lactamase (ESBL) in the urine. ESBL are enzymes produced by bacteria that make them resistant to many common antibiotics. These resistant bacteria often cause infections including urinary tract infections. The resident was placed on contact precautions on 03/08/26 due to the ESBL in the urine. Review of urine culture results on 03/07/26 revealed Resident #66 had two different strains of Escherichia coli in her urine. Both strains were resistant to 12 of 17 antibiotics listed on the culture. Intravenous antibiotics were ordered at that time. Interview with Medication Aide #228 on 03/09/26 at 8:04 A.M. revealed Resident #66 was on contact precautions due to a urinary tract infection. Observations on 03/09/26 at 8:10 A.M. revealed a sign for contact precautions outside Resident #66's room on the wall beside the door. At that time, a contracted phlebotomist was observed drawing blood from Resident #66. The phlebotomist was wearing gloves but did not have on a gown to protect her clothing. After exiting the room, the phlebotomist confirmed she drew blood from Resident #66 without wearing a gown. She stated she was not aware the resident was on contact precautions, despite the sign beside the door. The phlebotomist verified she had blood to draw from at least two other residents in the facility. The phlebotomist was then observed to enter another residents room (Resident #50) to draw blood from him. Review of the facility policy titled Isolation-Categories of Transmission-Based Precautions dated 2001 revealed Contact Precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment. Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed. Interview with Licensed Practical Nurse (LPN) Unit Manager #184 on 03/12/26 at 7:40 A.M. confirmed Resident #66 was on contact precautions. She stated the phlebotomist should have worn a gown when drawing blood from the resident. She stated not wearing a gown could spread infection to the next person that she takes care of. She stated the bacteria could be on the bed sheets and get on her clothes and then spread to the next person. In addition, observation of catheter care for Resident #66 on 03/11/26 at 10:00 A.M. by CNA #210 revealed she cleansed only the catheter tube itself. She did not cleanse the skin of the labia and did not cleanse around the urethral meatus. Once done with the care, CNA #264 poured the water from the basin used for catheter care down the hand sink in the room (Resident #66 had a room mate which was Resident #83). Resident #66 was on contact precautions for ESBL of the urine. Interview with CNA #210 on 03/11/26 at 10:00 A.M. revealed that is how she normally does catheter care (when asked why she cleansed the catheter tube only and did not cleanse the resident's skin at all). Interview with LPN Unit Manager #184 on 03/11/26 at 10:15 A.M. revealed the water from catheter care should not be poured down the hand sink since the resident has ESBL in her urine. On 03/11/26 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 10:43 A.M. she further confirmed the aide should have cleansed the labia and urinary meatus during catheter care, in addition to cleansing the catheter tube. On 03/12/26 at 7:40 A.M. she stated that not cleaning the skin around the catheter tubing could lead to infection.