STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365461	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Muskingum Skilled Nursing & Rehabilitation	501 Pinecrest Drive Beverly, OH 45715

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - 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 observation, record review, interview, policy review, and review of hospital records, the facility failed to ensure a resident experiencing a decline in respiratory condition who requested to be sent to the hospital for evaluation and treatment for shortness of breath had the hospital transfer request approved. The resident continued to decline for 24 hours until she was subsequently sent to the hospital as originally requested. This affected one resident (Resident #19) of one resident reviewed for change in condition. Actual Harm occurred on 03/18/26 when Resident #19, an alert and oriented resident with conditions of chronic obstructive pulmonary disease (COPD) and respiratory failure, exhibited a change in condition beginning on 03/08/26 as evidenced by shortness of breath, coughing and sputum production, on 03/18/26 the resident requested to go to the hospital due to difficulty breathing but the medical provider stated she would be monitored in-house. There was no evidence that Resident #19 was made aware of the medical provider's order to monitor in house and no evidence Resident #19 was given the option to request to be sent to the hospital again. On 03/19/26, Resident #19's condition continued to decline and her oxygen saturation dropped to 89 percent with oxygen in place. Resident #19 was then sent to the hospital and admitted for treatment of acute hypoxic respiratory failure, sepsis, and pulmonary infiltrates. In addition, the facility failed to ensure the bowel protocol was initiated for a resident without a bowel movement for three or more days that affected one resident (Resident #36) of three residents reviewed for bowel protocol, failed to communicate effectively with hospice providers to ensure hospice services were coordinated that affected three residents (Residents #41,#47, and #48) of four residents reviewed for hospice services, and failed to complete accurate skin assessments and provide transportation to appointments that affected one resident (Resident #28) of one resident reviewed for skin concerns. The facility census was 38.Findings include:1.Record review revealed Resident #19 was admitted to the facility on [DATE] with diagnoses including end stage renal disease, atrial fibrillation, and peripheral vascular disease. Review of a care plan dated 02/26/19 revealed Resident #19 had an alteration in oxygen exchange or perfusion related to chronic respiratory failure and chronic obstructive pulmonary disease (COPD). The goals were for the lungs to be clear to auscultation and oxygen saturation to be above 90 percent, respirations to be unlabored, and for the resident to show adequate oxygen perfusion. Interventions included assess lung sounds per orders and nursing judgement report abnormal breath sounds to provider; bi-pap as ordered, see orders for settings, at times resident refuses; maintain head of bed elevated to prevent shortness of breath; evaluate shortness of breath for pain and discomfort when breathing and administer medications as ordered to relieve; monitor vital signs as ordered and report abnormalities to provider; nursing to monitor resident and assess for effectiveness of respiratory treatment, vital signs, lung sounds, mental status, skin color, and report abnormalities to provider and nursing to assure set up of all required equipment and clean up after; provide oxygen as ordered; and provide respiratory treatments as ordered. (continued on next page)

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

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of a care plan dated 02/26/19 revealed Resident #19 had an alteration in respiratory function and was at risk for infections related to chronic respiratory failure and COPD. The goal was to keep oxygen levels at desired levels per physician. Interventions included but were not limited to administer oxygen as ordered; medications as ordered; monitor lung sounds as ordered; monitor oxygen as ordered; oxygen per nasal cannula at 3 liters (L) per nasal cannula at all times, and observe for signs and symptoms of dyspnea such as labored respiration, low oxygen saturation, use of accessory muscles, cyanosis, changes in mental status, and tachypnea. Review of an order dated 07/25/25 revealed Resident #19 had an order for albuterol sulfate HFA inhalation aerosol solution 108 micrograms/ACT two puffs inhale orally every four hours as needed for shortness of breath/congestion; an order dated 09/26/25 revealed Resident #19 was receiving humidified oxygen via nasal cannula continuously at three L per minutes and to check oxygen saturation each shift. Review of the Minimum Data Set (MDS) assessment, dated 02/19/26, revealed Resident #19's cognition remained intact, had no behaviors, and received oxygen therapy. Review of a nursing note dated 03/08/26 at 4:45 P.M. by Licensed Practical Nurse (LPN) #100 revealed staff alerted writer to Resident #19 due to shortness of breath and increased anxiety. Resident #19 was in bed with the head of bed at 90 degrees, oxygen was in place via nasal cannula at two L, oxygen was increased to four L and a rescue inhaler was given. Resident #19 had increased anxiety related to shortness of breath, color was flesh tone and had quick open-mouthed breathing. Review of an additional nursing note dated 03/08/26 at 6:20 P.M. by LPN #100 revealed the on-call physician service was made aware of Resident #19's condition, vital signs and increasing oxygen to four L to get oxygen saturation above 90 percent. A new order was received to give Mucinex 60 milligrams (mg) one tab by mouth three times a day and continue with as needed nebulizer treatment as previously ordered. Maintain oxygen at 4 L as needed to maintain oxygen saturation above 89 percent. Review of a nursing note dated 03/17/26 at 12:08 P.M. by LPN #100 revealed a new order was received from Nurse Practitioner (NP) #200 for Resident #19 to have a chest x-ray, two-view due to continuing to experience shortness of breath at times with aerosol treatments given per orders. There was no documentation in the medical record including vital signs, oxygen saturation level, a physical assessment, lung sounds, and condition of Resident #19 that precipitated LPN #100 notifying NP #200. Review of a nursing note dated 03/17/26 at 1:58 P.M. by LPN #100 revealed the chest x-ray results showed mild congestive heart failure. NP #200 was notified, dialysis would be notified, and no new orders at present. Review of a nursing note dated 03/18/26 at 3:22 A.M. by LPN #105 revealed Resident #19 requested to be sent to the hospital for shortness of breath. The on-call providers were notified and asked for the resident's oxygen level which was 99 percent. The on-call medical provider stated to continue to monitor resident and not send her out to the hospital. There was no additional information related to an assessment of Resident #19 including a physical assessment, additional vital signs, or lung sounds and there was no evidence Resident #19 was notified of the on-call's instructions or given the opportunity to request to be sent out to the hospital. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of a nursing note dated 03/18/26 at 3:27 A.M. by LPN #105 revealed Resident #19's vital signs were: blood pressure, 142/58 mm/Hg (normal reading 120/80), temperature 97.5 degrees Fahrenheit (F) (normal reading 98.6), respirations 20 breaths per minute, heart rate of 80 beats per minute, and oxygen saturation of 99 percent on four L of oxygen. Review of a pre dialysis evaluation note dated 03/18/26 at 5:54 A.M. by LPN #105 revealed Resident #19 had no signs of difficulty breathing, she did have shortness of breath noted, a moist and loose productive cough, and a moderate amount of secretions. Review of a MAR dated March 2026 revealed Resident #19 received a nebulizer treatment on 03/19/26 at 8:45 P.M. which was ineffective. Review of a nursing note dated 03/19/26 at 9:20 P.M. by LPN #109 revealed Resident #19 was short of breath, oxygen level was at 89 percent, the on-call medical provider was notified, oxygen was turned up and oxygen saturation was still at 89 percent. A new order was given to send Resident #19 to the emergency room. Review of a nursing note dated 03/19/26 at 10:00 P.M. by LPN #109 revealed the squad had arrived, Resident #19 was transferred and on her way to the local hospital. Report was called to the emergency department. Review of a nursing note dated 03/20/26 at 4:37 A.M. by Registered Nurse (RN) #117 revealed Resident #19 was admitted to the hospital for hypoxic respiratory failure, sepsis, and pulmonary infiltrates. Review of a hospital note dated 03/20/26 at 2:28 P.M. revealed Resident #19 presented to the emergency department on 03/19/26 with complaints of shortness of breath. She stated shortness of breath began about a week ago in conjunction with more coughing and increased sputum production. A chest CT showed numerous nodules throughout the lungs, enlarged distal common bile duct calculus with associated intrahepatic and extrahepatic biliary ductal dilation. Resident #19 was admitted for further workup and management of sepsis secondary to pneumonia acute hypoxic respiratory failure. Resident #19 was started on empiric intravenous (IV) antibiotics for sepsis. Resident #19 had increased cough and sputum production and chest CT showed multifocal nodules procalcitonin elevated and was started on IV ceftriaxone and doxycycline. Resident #19 used two to three L of oxygen at baseline but stated she had not been using her oxygen for quite some time and required 4 L via nasal cannula on admission to maintain saturations and was suspected for COPD in the setting of acute pneumonia. DuoNeb breathing treatments were scheduled and IV methyl prednisone was started. During an interview on 05/11/26 at 3:45 P.M., LPN #100 stated Resident #19 recently had a change in condition and needed to have an as needed nebulizer treatment ordered related to thick sputum which made it hard for her to breathe. LPN #100 stated she was not aware if there was a delay in treatment for Resident #19 but if a resident had asked her to go to the hospital and the provider did not want to send them, she would inform the resident of the option to be treated in house and if they still wanted to go to the hospital, she would send them to the hospital. LPN #100 denied having knowledge that Resident #100 was having difficulty breathing on 03/19/26. During an interview on 05/12/26 at 7:32 P.M., LPN #105 stated Resident #19 had been coughing up and having a hard time breathing but would feel better after receiving a breathing treatment. Resident (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	#19 always had a breathing treatment in place, despite seeing the order was for 03/08/26. Resident #19's baseline was to wear oxygen at 3 L per minute via nasal cannula. LPN #105 stated when assessing Resident #19, she listened to her lungs which were wheezing, but she wasn't using accessory muscles to breathe and a breathing treatment was given with no further concerns. LPN #105 stated resident had been coughing up a cream-colored sputum and the physician wanted to treat Resident #19 in house and the resident had been okay with that. LPN #105 confirmed there was no documentation of additional assessment completed or resident being informed of physician's orders to treat in-house. During an interview on 05/12/26 at 9:24 A.M., NP #200 stated Resident #19 was alert and oriented, doesn't always ask to go out to the hospital, and knows when she needs help. NP #200 stated if Resident #19 had asked her to go out to the hospital, she would have sent her. If she had been the on-call provider, she would have wanted to know more than just Resident #19's oxygen saturation related to shortness of breath and would like to have known about lung sounds, vital signs, if she was using accessory muscles. NP #200 stated timing matters when someone has sepsis because the longer you wait to treat, the harder and longer it takes to treat. NP #200 stated she felt this incident was a delay in care. NP #200 read the notes and stated there was no indication Resident #19 was made aware of what the provider had stated about being treated in-house, about having the option to still go to the hospital, and no documentation of physical assessment. NP #200 stated despite Resident #19 still attending dialysis, it was the facility's responsibility to ensure the resident received the care and services needed to prevent major illness. During an interview on 05/12/26 at 10:18 A.M., Behavioral Health Tech (BHT) #400 stated one day in March (2026), Resident #19 was really struggling to breathe. Certified Nursing Assistant (CNA) #139 had retrieved BHT #400 and asked for help because she had notified the nurse, LPN #100, at least three times of Resident #19 struggling to breathe and was dismissed each time. BHT #400 went to see Resident #19 who was using accessory muscles to breathe. BHT #400 stated she grabbed Registered Nurse (RN) #117 who assessed Resident #19 and administered a breathing treatment which helped the resident to feel better. BHT #400 stated she wouldn't have access to view documentation but she did make this observation. During an interview on 05/12/26 at 11:32 A.M., CNA #139 stated during her shift on either 03/16/26 or 03/17/26, Resident #19 had been short of breath and in distress. CNA #139 stated Resident #19's oxygen saturation kept dropping to 86 percent with oxygen in place via nasal cannula at 3 L per minute. CNA #139 stated she told the nurse (LPN #100) three times about her concerns with Resident #19's oxygen levels who stated it was an ongoing issue and she would check on her. CNA #139 stated LPN #100 did not ever go check on Resident #19 so she asked BHT #400 to intervene who then grabbed RN #117 and RN #117 gave Resident #19 a breathing treatment. CNA #139 stated Resident #19's eyes appeared sunken in and dark, her skin was pale, and her lips were blue. CNA #139 stated Resident #19 was clearly in distress and using her accessory muscles to breathe and stated she wanted to go to the hospital several times but no one would listen. During an interview on 05/12/26 at 11:48 A.M., RN #117 stated she could not recall if any staff had asked her to assess Resident #19 at any point in time for shortness of breath. RN #117 stated she was aware of new orders during the timeframe related to breathing treatments but could not recall additional information. Review of an undated policy titled Status Change in Resident Condition- Notification revealed the facility should promptly notify the resident, their attending physician, and the responsible party of (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	changes in resident condition and/or status. Regardless of the resident's mental or physical condition, nursing will information residents of any changes in their medical care or nursing treatments. The licensed nurse will record in the resident's medical record any changes in the resident's medical condition or status. If a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted by the assessment coordinator. Review of online information obtained from the University of Pittsburg Medical Center website (https://www.upmc.com/services/divsion-infectious-diseases/conditions/sepsis) dated 2025 revealed the six main symptoms of sepsis were shortness of breath; fever, chills, feeling very cold; high heart rate or low blood pressure; extreme pain or discomfort; sweaty or clammy skin; and being confused or feeling a bit lost. Sepsis was an emergency blood infection that could lead to death within hours without proper treatment. Sepsis could progress quickly and cause death within 12 hours and the risk of death increases by 7.6 percent for every hour that passes without treatment and getting quick treatment can be the difference between life and death. Four types of infections that were more likely to lead to sepsis include pneumonia, a UTI, skin infections and gut infections. Those at a higher risk for sepsis include people 65 or older, weakened immune systems, having had a recent severe illness or hospital stay, or chronic illnesses such as lung disease or kidney disease. 2.Record review revealed Resident #36 was admitted to the facility on [DATE] with diagnoses including gastroesophageal reflux disease and hypertension. Review of an order dated 12/28/22 revealed Resident #36 had an as needed order for milk of magnesia suspension 400 mg/5ml give 30 ml by mouth every 24 hours as needed for constipation. Review of an order dated 09/26/25 revealed Resident #36 had an as needed order for Dulcolax suppository, insert one suppository rectally every 24 hours as needed for constipation; if no results from milk of magnesia on the subsequent shift still no bowel movement, may administer one suppository. Review of an order dated 09/26/25 revealed Resident #36 had an as needed order for fleet enema 7-19 gm/118 ml insert one application rectally every 24 hours as needed for constipation; may administer fleet enema if there is no bowel movement on the subsequent shift (after suppository) and may repeat one time. Review of an additional order dated 09/26/25 revealed if Resident #36 does not have a bowel movement after following steps one, two and three, notify physician of no bowel movement. Review of bowel movement documentation revealed Resident #36 did not have a bowel movement from 04/26/26 through 04/30/26, five days total. Review of the medication administration record (MAR) for April 2026 revealed Resident #36 did not receive any as needed intervention related to bowel movement protocol from 04/26/26 through 04/30/26. Interview on 05/12/26 at 11:46 A.M. with the Director of Nursing (DON) confirmed there was no bowel movement and no intervention for five days for Resident #36. Review of an undated policy titled Bowel Management and Treatment revealed for existing residents, (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	upon initiation of the program, the licensed nurse or dietician will assess the resident's bowel pattern, history or potential for constipation, laxative use, intake of fluids and fiber, and daily exercise. If constipation is a concern, the licensed nurse will also access the resident for depression, dementia, medications, and physical constraints to toileting to identify possible contributing factors. The dietician will obtain a history of the resident's usual daily intake based on current likes/dislikes and adjust the diet as needed. The bowel program appropriate for resident's needed will be implemented. Resident will be encouraged to participate in routine exercise, and consume fluids and fibers as tolerated and as ordered. All of the above will be documented in the care plan. Residents who have not had a bowel movement for three consecutive days will have the following protocol initiated, unless, resident has individual orders specific to bowel management, or where the orders below would be contraindicated for the resident. 1. Initial nurse receiving the alert and identifying the lack of a bowel movement for three days will begin the following bowel protocol for the residents on the list:a. Assess bowel sounds.b. Administer 30 ml of milk of magnesia.c. If the resident refuses the milk of magnesia, the nurse will notify the attending physician and document such on the MAR and in the nurses' notes.d. Document on the MAR and in the nurses' notes when the resident has a bowel movement and then the resident will be placed on the modified promotional bowel regimen as is listed above.2. The medication nurse on the next shift will check the list upon beginning her shift and the following will be performed.a. Assess bowel sounds.b. If the resident does not have a bowel movement on the prior shift after receiving the milk of magnesia, the licensed nurse will administer a suppository per physician's order.c. If the resident refuses the suppository, the nurse will notify the attending physician and document such on the MAR and in the nurses' notes.d. Document on the MAR and in the nurses' notes when the resident has a bowel movement and then the resident will be placed on the modified promotional bowel regimen as is listed above.3. The medication nurse for the third consecutive shift will check the list at the start of her shift and the following will be performed: a. Assess bowel sounds.b. If the resident does not have a bowel movement on the prior shift after receiving the suppository, the licensed nurse will administer an enema per physician's order.c. If the resident refuses the enema, the nurse will notify the attending physician and document such on the MAR and in the nurses' notes.d. Document on the MAR and in the nurses' notes when the resident has a bowel movement and then the resident will be placed on the modified promotional bowel regimen as is listed above.e. If the resident does not have a bowel movement within one hour of receiving the enema, notify the attending physician for further instruction and document such in the MAR and in the nurses' notes.The promotional protocol includes residents with a history of difficult and infrequent passing of hard dry stools and fewer than three stools a week and those who voice a sensation of incomplete evacuation are placed on a promotional bowel regimen. Review medications, obtain physician's orders to hold all laxative and enema orders including stool softeners and bulk laxatives, daily administration of natural laxative of prune/fiber mixture with mediation pass, increase fluid intake for the resident, offer 1/2 cup of yogurt to the resident daily. Assess bowel sounds each shift and document. Each shift, the licensed nurse documents on the MAR/TAR when the resident has had a bowel movement. 3. Medical record review revealed Resident #28 was admitted to the facility on [DATE] with diagnoses including candidiasis of skin and nails, eczema, anemia, and obesity. Review of Resident #28's impaired skin integrity plan of care related to immobility, incontinence, fungal areas, bed ridden, prefers to lay on right side, scratches and picks at wounds, and refuses appropriate hygiene care at times dated 10/29/26 revealed to educate resident on picking, encourage not to pick, inspect skin during routine daily rounds, medication as ordered, treatments as ordered, and gel overlay to bed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	a. Review of Resident #28's skin observation note dated 10/03/25 and 10/10/25 revealed the resident continues to have red rash on right side, under skin folds and between breasts. Open area to abdomen with treatment in-place. Review of Resident #28's progress note dated 10/22/25 revealed the resident refused to go to a dermatology appointment and rescheduled for 11/26/25. The resident was in agreement to go to the dermatologist if she could have a Xanax (anti-anxiety) prior to the appointment. Review of Resident #28's progress note dated 11/26/25 revealed the transportation company was late, and the dermatology office could not accommodate the late arrival and would call back to reschedule. Review of Resident #28's progress note dated 12/04/25 revealed the wound Nurse Practitioner (NP) was at beside and the resident complained of itching related to skin issues. New orders received for hydroxyzine 10 milligrams every eight hours for itching. Review of Resident #28's progress note dated 12/15/25 revealed transport called and cancelled transport for today to go to the dermatologist. Appointment will be rescheduled as soon as transport is available. Review of Resident #28's progress note dated 02/19/26 revealed the wound NP reported the skin looks better this week, less redness and less complaints of itching. Interview with the Director of Nursing (DON) on 05/11/26 at 2:19 P.M., revealed not all of Resident #28's dermatology appointments were documented in the medical record, and she had to review emails to determine how many appointments have been scheduled with the dermatologist for Resident #28. The DON reported on 10/13/25 there was no transportation, on 10/22/25 the resident had refused, on 11/20/25 transportation cancelled, 11/26/25 transportation was late and the dermatologist office could not see her, 12/15/25 transportation cancelled, 12/22/25 there was no transportation, 01/06/26 no transportation, 01/16/26 no transportation, and 02/05/26 no transportation. The resident's next dermatology appointment is scheduled for 05/12/26 and she had called and verified transportation arrangements with the company. b. Review of Resident #28's physician note dated 04/29/26 revealed the resident had suspected psoriatic arthritis (arthritis that affect people who have psoriasis (skin condition that causes itchy, scaly patches on skin) and would benefit from immunosuppressive therapy to control the issue. The psoriasis on the head and back was severe. Awaiting referral to rheumatology. Review of Resident #28's nursing note dated 04/29/26 revealed the physician discontinued the Clobetasol (steroid cream) and ordered Clotrimazole cream 1 percent (antifungal cream) to skin fold rash daily and rheumatology appointment. Review of Resident #28's nursing note dated 04/30/26 revealed the wound care nurse wanted Clobetasol 0.05 percent twice daily ordered and to discontinue the Clotrimazole cream. Review of Resident #28's skin assessment dated [DATE] revealed the resident skin was intact and continue treatment to rash. Review of Resident #28's nursing note dated 05/05/26 revealed the facility NP stated to continue (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	cream per the wound NP orders for Clobetasol 0.05 percent twice daily. Review of Resident #28's physician note dated 05/06/26 revealed the resident's skin condition doesn't appear to be fungal. Discontinue Clobetasol and trial pimecrolimus to prevent further skin atrophy. Review of Resident #28's skin assessment dated [DATE] revealed skin was intact. Continue treatment for redness to folds. No new areas noted. Review of Resident #28's orders and medication and treatment administration records dated 05/2026 revealed on 04/30/26 Clobetasol Propionate external cream (steroid) was re-ordered to apply to abdomen folds and rash area topically twice daily for a rash. On 05/05/26 the Clobetasol Propionate was discontinued and rewritten on 05/05/26 to apply twice daily to abdomen, breast, skin folds, and arm pit. The order was discontinued again on 05/06/26 and a new order was written for Pimecrolimus cream 1 percent apply to skin fold rash topically every eight hours as needed for rash. The Pimecrolimus cream was never applied. Interview on 04/28/26 at 10:32 A.M., with the Ombudsman revealed he had been working with the facility due to having issues with transporting Resident #28 to dermatology appointments and the resident doesn't feel the facility was addressing her skin issues appropriately and now she had an open area on her torso the facility was not applying a treatment to. Observation on 05/11/26 at 10:35 A.M. of Resident #28 with Registered Nurse (RN)/Wound Nurse #117 confirmed Resident #28 had an open area on her abdomen the size of a dime with a yellow center, a red rash on the torso of her body, and dry flaky skin on her head. Interview on 05/11/26 at 11:36 A.M., with Registered Nurse (RN)/Wound Nurse #117 confirmed the physician didn't agree with the wound NP order for steroid treatment and kept changing the treatment orders. The RN confirmed the physician had ordered pimecrolimus cream to the area, however staff never administered the medication, and the resident had a rash, and the medication should have been applied. The RN reported she was going to clarify orders on the pimecrolimus. Interview on 05/12/26 at 9:24 A.M., with Resident #28 confirmed the open area on the abdomen had been there for months and she had photos to confirm. The resident reported the area started out as a blister and then opened. She had asked staff for a band-aid due the area was draining and the staff would tell her no because she didn't have an order. The resident reported she had been working with the Ombudsman for help to find transportation to appointments and treatment to open area on her abdomen. Interview on 05/12/26 at 9:37 A.M., with Licensed Practical Nurse (LPN) #100 confirmed she had completed Resident #28's skin assessment on 05/08/26 and didn't include the open area on her assessment due to the area didn't appear new to her and it was not draining. 4. Medical record review revealed Resident #41 was admitted to the facility on [DATE] with diagnoses including encephalopathy, osteomyelitis, chronic obstructive pulmonary disease, diabetes mellitus, asthma, dementia, major depression, urge incontinence, anxiety, long QT syndrome, insomnia, pain, peripheral vascular disease, Vitamin D Deficiency restless leg syndrome, gastritis, constipation, occlusion and stenosis of carotid artery, hyperglycemia, hyperlipidemia, nocturia, and hypomagnesemia. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #41's admission minimum data set (MDS) accepted on 02/26/26 revealed the resident observation period ended on 02/17/26 for the assessment. Resident #41 was admitted to the facility on [DATE] under hospice services. Review of Resident #41's hospice plan of care dated 02/11/26 revealed to contact hospice for change in resident condition, administer medications as ordered, and hospice to collaborate care with facility staff. a. Review of Resident #41's hospice note dated 02/26/26 authored by Chaplin #201 revealed the Chaplin was visiting and the roommate reported that Resident #41 mistakenly received his mediation. The resident was confused as evidence by stating that this Chaplin was on TV and that he was as well. The resident could not remember the name of his phone. The Chaplin notified the hospice office via team thread. The Chaplin forgot to notify the facility at the time of his visit. The Chaplin called the facility and spoke to Licensed Practical Nurse (LPN) #100 who stated the facility was aware of the situation. Review of Resident #41's hospice note dated 02/26/26 authored by Hospice Registered Nurse (RN) #202 revealed the nurse spoke to the hospice physician about the medication error from the facility. New orders to monitor for four days. No change in medication at this time. Interview on 04/28/26 at 3:39 P.M., 3:45 P.M., and 04/29/26 at 7:10 A.M. and 8:21 A.M. with the Director of Nursing (DON) confirmed certified medication aide (CMA) #108, who was also the social service designee, admission coordinator, marketing director, certified nurse aide (CNA), and the facility's beautician, had administered Resident #49's medication to Resident #41 on 02/25/26. The DON confirmed the resident was admitted to hospice services on 02/10/26, however hospice was not notified of the medication error until 02/26/26. b. Review of Resident #41's electronic medical record and hospice binder revealed no evidence of hospice notes or hospice plan of care. Interview on 04/29/26 at 10:32 A.M., with the DON confirmed the hospice staff usually talk with her or floor staff when they enter the building, however they don't always follow up with staff prior to leaving. If there was a new order, hospice usually would email her the new order. The facility currently has three hospice providers providing services to the residents. Interview on 05/05/26 at 9:53 A.M., and 05/06/26 at 8:30 A.M., with the DON con

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on record review, interview, review of infection control log, review of facility assessment, and policy review the facility failed to ensure adequate staffing was in place to meet the needs of the residents were met. This had the potential to affect all 38 residents residing in the facility. Findings include: Review of the infection control log dated May, 2026 revealed no evidence a log had been started. Review of the concern log dated April, 2025 to April, 2026 revealed the facility had no concerns reported each month. Interview on 04/28/26 at 10:32 A.M., with the Ombudsman revealed he had an open case that's been ongoing regarding call light response time and staff attitude. Residents had reported the staff attitudes had improved since the facility terminated a Certified Nurse's Aide employment, but it's not completely resolved. Interview on 04/28/26 at 2:44 P.M., with Scheduler/Dietary Manager/Human Resource #111 revealed the staffing level was determined by the census. On dayshift and nightshift, two nurses are scheduled. The Scheduler #111 indicated scheduled nursing was either a Registered Nurse (RN), Licensed Practical Nurse (LPN) or Medication Tech (MT). On dayshift she tries to schedule three Certified Nurses Aides (CNA) and nightshift two CNAs. Per Scheduler #111, Sunday through Tuesday there was usually an MT an LPN/RN and Wednesday to Saturday two LPN/RN. The facility currently only has three RN's (Director of Nursing (DON), Assistant Director of Nursing (ADON), and the facility shares a Minimum Data Set (MDS) Nurse). The ADON has been working the floor since 04/12/26 due to staff shortage. The ADON was also the Infection Preventionist and Wound Nurse. The MDS Nurse works three days a week, one week alternating with two days the following week. Interview on 05/04/26 at 9:23 A.M., with Resident #25 revealed the facility needs to upgrade staffing, doesn't want to say more when asked if there were needs that were not being met. Interview on 05/05/26 at 8:52 A.M., with Resident #8 revealed there was not adequate staffing on night shift. Sometimes she doesn't get her medication until 11:00 P.M. The resident reported she doesn't use her call light frequently; however, she can hear call lights on her hall go off over for extended periods of time. Interview on 05/05/26 at 9:23 A.M., with Resident #28 confirmed there was not adequate staffing to meet her needs. The call lights were not answered timely. Sometimes staff will answer the call lights but do not address her needs and say they will return and never come back. Medications were not administered timely and sometimes she doesn't receive the correct medications. The resident reported that sometimes she requests Motrin and sometimes she will get it and sometimes she won't. The facility doesn't pass ice timely as well. Interview on 05/05/26 at 10:26 A.M., with Resident #31 revealed the facility was not adequately staffed. The MT was not competent to provide care due to medications not being administered timely and sometimes he receives the wrong medications. Sometimes it takes up to three hours before staff will answer his call light. Interview on 05/06/26 at 7:22 A.M., with LPN #105 confirmed it was very stressful when she is the only nurse on midnight shift and she doesn't always have time to document care she had provided to residents. Interview on 05/06/26 at disclosed time, with anonymous Staff Member #500 confirmed the ADON had been working on the floor at least twice a week. The anonymous Staff Member #500 reported residents have voiced concerns that nurses don't follow up timely with care. Interview on 05/07/26 at disclosed time, with anonymous Staff Member #501 confirmed there isn't enough staff to meet the resident needs timely. Showers were not being done per the resident preferences and call lights were not being answered timely due to the staff were lazy. Nurses are not doing their job. The management staff have multiple rolls to fill. The Social Service Designee also works on the floor as a CNA and MT. She is also the facility's beautician, admission director and marketing director. The Dietary Manager was also the scheduler and human resources. The Medical records staff was also the activity director. The ADON was also the Infection Preventionist and Wound nurse. The ADON has been working the floor at least two days a week and occasionally the DON has been working the floor to cover spots. The Administrator doesn't engage (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	with staff. Interview on 05/11/26 at 10:46 A.M., with RN #117 confirmed there had been five or six infections thus far in May, however she had not started the tracking or trending. The RN #117 confirmed due to the nursing shortage she had been working on the floor three 12 hours days a week and had been working on the Infection Control when she had some down time on those days. The RN confirmed documentation was an issue when MTs were working due to the MTs were not permitted to document in the medical records and it was the nurse's responsibility. Interview on 05/12/26 at 8:15 A.M. and 8:25 A.M., with Housekeeper Supervisor (HKS) #113 confirmed she could print the call light report, however Corporate told her she could not print the report or let the surveyor review the report and if there was a concern with call lights the facility would have addressed it internally. Interview on 05/12/26 at 8:55 A.M., with the Administrator and Director of Nursing (DON) confirmed Corporate had advised them not to release the call light reports due to the reports were not part of the medical record. The Administrator confirmed there was a general concern from the Ombudsman in February (2026) regarding call lights however she didn't complete a concern form, however moving forward she would start completing concern forms. The Administrator reported during the all staff meeting in February (2026) that the facility reviewed the call light response time. The Administrator reported staff complete call lights audits, however there was no documented evidence they were completed to provide to the surveyor. Interview on 05/12/26 at 9:43 A.M., with Nurse Practitioner (NP) #200 confirmed RN #117 had been working the floor, and she makes sure she gives orders to an LPN/RN. Interview on 05/12/26 at disclosed time with an anonymous contracted employee confirmed the facility doesn't have adequate staffing. The call lights were not answered timely, and the contracted employee has a difficult time finding staff to assist the residents. There currently is a lack of communication with staff. The contracted employees have reported changes in residents' conditions, and they are not followed up timely. Follow up interview on 05/13/26 at 8:17 A.M., with Scheduler #111 confirmed the information conducted during the interview on 04/28/26. Scheduler #11 confirmed RN #117 started working three 12-hour shifts on floor on 04/12/26. Prior to that she was working five eight-hour shifts. RN #117 was also the Assistant Director of Nursing (ADON), Infection Preventionist (IP), and wound nurse. The Scheduler reported she had no idea what the requirement hours were for the IP position. To ensure RN coverage the DON works Monday through Friday and every other weekend, the ADON and DON will alternate with occasionally the MDS Nurse helping to cover the eight-hour shifts. The MTs were overseen by the DON. The nurse who works with the MTs was also responsible for completing all the assessments, charting, and nursing care for residents in the building. The Scheduler reported she doesn't know what the facility assessment indicated the facility needed for staffing coverage. The nurses were not crazy about the MTs, and she relays the nursing concerns. Currently the facility has four full-time LPN's, two part-time LPNs, and two as needed LPNs. The facility has hired two LPN's and one RN; however, they have not started yet. The facility has no opening jobs for LPN's, one weekend opening for RN, and one part-time midnight opening for CNA. The Scheduler reported she determines the staffing by dividing the hours by the census. The DON reviews the schedules and will make changes if needed. Interview on 05/13/26 at disclosed time with anonymous Staff #506 revealed the staff members don't feel there was adequate staffing on both shifts. The showers, checking and changing residents for incontinence needs, and turning residents were not being done per the residents' plans of care. The nurses complain when they work with MT's because then they are responsible for all the residents in the building. The MTs were usually scheduled on one hall and the nurse on the other hall; however, the nurse was responsible for nursing care, assessments, and charting. The MTs can only administer medications. There had been some complaints on night shift staffing especially on the days residents go to dialysis. Two of three residents require extensive assistance to get ready early in the morning. Review of the facility's policy titled Antibiotic Stewardship dated 01/2020 revealed the IP would track, record, and analyze infections related to residents, staff, volunteers, and visitors. Review of the facility assessment dated 01/2026 revealed the staffing levels were based upon the acuity of the residents and resident (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	population. The staffing patterns may fluctuate depending upon daily census and resident needs. The facility promotes continuity of care and resident-centered culture by providing consistent assignments for our direct care staff. The type of staff didn't include MTs, nor did the assessment include the number of staff required.

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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 policy review.the facility failed to ensure food was prepared and served in a sanitary manner. This had the potential to affect 38 of 38 residents who received food from the kitchen. Findings include:Observations on 05/07/26 starting at 11:17 A.M. through 12:24 P.M. revealed the following:At 11:55 A.M., [NAME] #126 reached into a bag of bread without gloves and touched four pieces of the bread, she removed the third and fourth pieces of the bread from the bag to make a grilled cheese. Dietary Manager (DM) #111 asked [NAME] #126 to throw the bread away, wash her hands and get new bread out with gloves on but did not remove the other two pieces of bread from the bag which were touched.At 12:00 P.M. observations of the window sill revealed dust and debris, the ceiling above the food preparation area had large amounts of dust around the air vent and on sprinkler system waterlines, the walls in the food prep area had food splatters.At 12:13 P.M., [NAME] #126 was holding tongs over the bin of chicken, barehanded. She dropped the tongs into the chicken, removed them, and grabbed a new pair of tongs. The remaining chicken in the bin was still served. Interview on 05/07/26 at 12:24 P.M. with DM #111 confirmed all findings. Review of an undated policy titled Food Storage revealed storage facilities should keep food safe, wholesome and appetizing. Food should be stored in an area that is clean, dry, and free from contaminants.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, policy review, review of fit testing, and review of the infection control log, the facility failed to properly store nebulizer masks and tubing and failed to maintain a comprehensive infection control log and ensure staff were fit tested. This affected two residents (Resident #19 and #48) but had the potential to affect 38 residents residing in the facility. Findings include:1.Record review revealed Resident #19 admitted to the facility on [DATE] with diagnoses including end stage renal disease and atrial fibrillation. Review of a care plan dated 02/26/19 revealed Resident #19 had an alteration in oxygen exchange/perfusion related to chronic respiratory failure and chronic obstructive pulmonary disease. The goal was for lungs to be clean to auscultation and oxygen saturation above 90%, respirations to be unlabored, and show adequate oxygen perfusion. Interventions included but were not limited to evaluate shortness of breath for pain and discomfort when breathing and administer medications as ordered to relieve and provide oxygen per orders, and to provide respiratory treatment per orders. Review of orders revealed an order dated 03/08/26 for Resident #19 to have albuterol sulfate inhalation nebulization solution 0.63 mg/3ml one unit inhale orally via nebulizer every six hours as needed for shortness of breath/congestion. Observation on 05/05/26 at 7:52 A.M. revealed Resident #19 was resting in bed and her nebulizer mask and tubing were laying directly on her bedside table. Observation on 05/05/26 at 1:31 P.M. revealed Resident #19 was seated in her wheelchair and her nebulizer mask and tubing were laying directly on her bedside table. Interview on 05/06/26 at 6:45 A.M. with Maintenance Director (MD) #112 confirmed Resident #19's nebulizer mask and tubing were lying directly on the bedside table. Interview of 05/06/26 at 6:54 A.M. with Certified Nursing Assistant (CNA) #145 confirmed Resident #19's nebulizer mask and tubing were lying directly on the bedside table. Review of an undated policy titled Hand Held Nebulizer revealed when nebulizer treatment has been completed, rinse the med neb cup with tap water and store at bedside on a paper towel or in a plastic bag. 2. Review of the COVID, Flu A, and RSV infection control binder revealed there was an outbreak of COVID from 11/20/25 to 12/20/25, Flu A from 01/22/26 to 02/09/26, and respiratory syncytial virus (RSV) from 03/16/26 to 04/01/26. Review of the facility's policy titled Respiratory Protection Program dated 09/15/20 revealed N95 fit testing would be performed when an employee is initially required to wear a respirator, and thereafter on an annual basis. Interview on 05/13/26 at 11:40 A.M. with Infection Preventionist (IP) #117 revealed she had just taken over IP in October 2025, and she was not able to find evidence new hires or current employees have been fit tested for respirators in the past year. The IP confirmed the staff were required to wear respirators (N95) during recent outbreaks of COVID, Flu A, and RSV. The facility has quarterly (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	education planned throughout the year and the next infection control was scheduled in September 2026, and she was planning on doing annual fit testing at that time. 3. Closed medical record review revealed R#48 was admitted to the facility on [DATE] with diagnosis of including urinary tract infection. Review of Resident #48's final urinalysis results dated 04/20/26 revealed Resident #48 grew greater than 100,000 CFU/ml of Escherichia Coli Extended-spectrum beta-lactamases (ESBL). Review of the infection control log dated 04/2026 revealed no evidence of Resident #48's infection. 4. Record review revealed Resident #31 was admitted to the facility on [DATE] with diagnosis including acute kidney failure and retention of urine. Review of Resident #31 final urinalysis results dated 05/02/26 revealed the urine culture grew 25-30,000 proteus mirabilis and was resistant to Cipro. Review of Resident #31's medication administration record dated 05/2026 revealed the resident had received six doses of Cipro 500 milligrams for a urinary tract infection. Review of the infection control log dated 04/2026 and 05/2026 revealed no evidence of Resident #31 proteus mirabilis or Cipro. 5. Review of May 2026 infection control log revealed no evidence of any infection logged on the control log. Interview on 05/13/26 at 10:36 A.M., with Registered Nurse (RN)/Infection Preventionist (IP)/Wound Nurse (WN) confirmed she had been working three 12 hours shifts on the floor the last three weeks due to a nursing shortage. The RN/IP/WN reported there had been five or six infections in May 2026 however she had not started the May infection control log (trending and tracking) at this time and had been trying to work on the infection control log during her free time as she works on the floor. The IP confirmed Resident #31 and R#48 infections were not logged on the infection control log. Review of the facility's policy and procedure titled Infection Prevention and Control Program undated revealed the facility would perform surveillance activities to monitior and investigate causes of infection and manner of spread in order to prevent infection in the facility. Review of the facility policy and procedure titled Antibiotic Stewardship dated 01/2020 revealed each facility would designate an infection control preventionist. The person would be responsible track, record, and analyze infections related to resident, staff, volunteers, and visitors.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of infection and antibiotic control logs, review of the facility assessment, interviews, and policy review the facility failed to ensure the Infection Preventionist (IP) dedicated time to IP duties to maintain a comprehensive infection control program. This affected Resident #31 and #48 with urinary tract infections but had the potential to affect all residents in the facility. The census was 38. Findings include:1. Review of May 2026 infection control log revealed no evidence of any tracking or trending for May 2026 as of 05/13/26. Interview on 05/13/26 at 8:17 A.M., with Scheduler #111 confirmed Registered Nurse (RN) /Infection Preventionist (IP) #117 started working three 12-hour shifts on floor on 04/12/26. Prior to that RN/IP was working five eight-hour shifts. RN #117 was also the Assistant Director of Nursing (ADON) and Wound Nurse. The Scheduler confirmed she was not aware of the hours the IP was required to work. Interview on 05/13/26 at 10:36 A.M., with Registered Nurse (RN) #117confirmed she had been working three 12 hours shifts on the floor the last three weeks due to a nursing shortage. The RN reported there had been five or six infections in May 2026 however she had not started the May infection control log (trending and tracking) at this time and had been trying to work on the infection control log during her free time as she works on the floor. Review of the facility assessment dated 01/2026 revealed no evidence of who the infection preventionist was or the hours required to ensure the facility maintained a comprehensive infection control and antibiotic stewardship program. The Infection Prevention and Control Program and Antibiotic Stewardship policy and procedures didn't include the time designated for the IP to ensure the program was accurate and comprehensive. 2. Closed medical record review revealed Resident #48 was admitted to the facility on [DATE] with diagnosis of including urinary tract infection. Review of Resident #48's final urinalysis results dated 04/20/26 revealed Resident #48 grew greater than 100,000 Colony Forming Units/milliliter (CFU/ml) of Escherichia Coli Extended-spectrum beta-lactamases (ESBL). Review of the infection control log dated 04/2026 revealed no evidence of Resident #48's infection. 3. Record review revealed Resident #31 was admitted to the facility on [DATE] with diagnosis including acute kidney failure and retention of urine. Review of Resident #31 final urinalysis results dated 05/02/26 revealed the urine culture grew 25-30,000 proteus mirabilis and was resistant to Cipro. Review of Resident #31's medication administration record dated 05/2026 revealed the resident had received six doses of Cipro 500 milligrams for a urinary tract infection. Review of the infection control log dated 04/2026 and 05/2026 revealed no evidence of Resident #31's potential infection was logged on the infection control log. Interview on 05/13/26 at 10:36 A.M., with Registered Nurse (RN) #117 confirmed Resident #31 and Resident #48's infections were not logged on the infection control log despite the infection control program being a responsibility of the IP, RN #117. Review of the facility's policy and procedure titled Infection Prevention and Control Program undated revealed the facility would perform surveillance activities to monitior and investigate causes of infection and manner of spread in order to prevent infection in the facility. Review of the facility policy and procedure titled Antibiotic Stewardship dated 01/2020 revealed each facility would designate an infection control preventionist. The person would be responsible track, record, and analyze infections related to resident, staff, volunteers, and visitors.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy review, the facility failed to ensure the resident's interdisciplinary team including the residents participated in the care planning process including care plan conferences. This affected four residents (#1, #4, #28, and #31) of five residents reviewed for care conferences. The facility census was 38.Findings include: 1.Record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease and type II diabetes. Review of a care conference sign in sheet dated 02/03/26 revealed individuals present at the care conference were Resident #1's representative, Director of Nursing (DON), and Social Services (SS) #108. Review of a care conference sign in sheet dated 04/08/26 revealed individuals present at the care conference were Resident #1's representative and SS #108. Interview on 05/04/26 at 11:01 A.M. with Resident #1 revealed she had not been asked to participate in care conferences and this is something she would like to do. Interview on 05/07/26 at 12:53 P.M. with SS #108 confirmed Resident #1 was not asked to participate in their own care conference and not the entire disciplinary team attended Resident #1's care conferences. The staff knows the conferences are held on Thursday. 2. Record review revealed Resident #4 was admitted to the facility on [DATE] with diagnoses including Tourette's, heart failure, anemia, and depression. Review of Resident #4's quarterly minimum data set (MDS) assessment completed 04/04/26 revealed a brief interview for mental status (BIMS) score of 8 indicating moderate cognitive impairments, a total severity score of 8, the resident had no displayed behaviors. The resident had lower extremity impairment on both sides, was dependent for oral hygiene, toileting, showering and bathing, upper body dressing, lower body dressing, putting on and taking off footwear, and personal hygiene. The resident was dependent for mobility and transfers. The resident was frequently incontinent of bowel and bladder. The resident had a feeding tube. Review of Resident #4's care plan meeting completed on 01/02/26 revealed all parties present included Resident #4 and their representative, social service designee #108 , and the director of nursing. Review of the care plan meeting minutes revealed not all members of the interdisciplinary team were present. 3. Review of Resident #28's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including acute respiratory failure with hypoxia, morbid obesity, congestive heart failure, personality disorder, depression, chronic obstructive pulmonary disease, hemoptysis, rheumatoid arthritis, drug-induced Cushing's, personality disorder, depression, generalized anxiety, post-traumatic stress disorder, personal history of suicidal behavior, gastro-esophageal reflux disease, poisoning by benzodiazepines, and sedative, hypnotic or anxiolytic dependence, in remission. Review of Resident #28's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident's (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Muskingum Skilled Nursing & Rehabilitation	501 Pinecrest Drive Beverly, OH 45715

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	brief mental status score was 15 (cognition intact). Review of the electronic medical record revealed Resident #28 attended care conferences on 04/08/25, 07/07/25, 10/09/25. Others in attendance were registered nurses and social service designee (SSD). Review of a handwritten care plan meeting note dated 12/18/25 revealed the Director of Nursing (DON) and the resident were in attendance. Review of a handwritten care plan meeting note dated 03/27/26 revealed the Resident and SSD were the only two in attendance. A note indicated the resident refused weights and no dietary changes were noted. Resident will let SSD know if she has any complaints or concerns. Interview on 05/05/26 at 9:24 A.M. with Resident #28 revealed she had never been invited or attended a care conference in the two years she had been a resident at the facility. Resident #28 reported last week after the surveyor had spoken to her staff had brought in a bunch of papers for her to sign, however she doesn't know what she signed. Interview on 05/07/26 at 9:42 A.M. and 11:22 A.M. with Social Service Designee (SSD) #108 revealed on 12/18/25 she had attended the care conference, however forgot to sign the sign in sheet. The SSD confirmed the only staff in attendance for the care conference were the DON and herself. The SSD confirmed on 03/27/26 she was the only staff present for the care conference. SSD reported there is times she is the only staff in attendance if the DON is not available. The other interdisciplinary team (dietary, therapy, physician, or the direct care staff) did not attend the care conference, nor did they share information with her before the meetings. The IDT is aware the care conference is held every Thursday. The SSD confirmed she was not aware of who was required to attend the meetings. Interview on 05/13/26 at 7:09 A.M., with the Minimum Data Set (MDS) Registered Nurse (RN) #118 revealed she was new to the position and was not aware of the day care conferences were held. The MDS RN #118 confirmed she had never attended a care conference at the facility. The MDS RN #118 reported her work hours are split between two buildings. She works Monday, Wednesday, and Thursday then alternates Tuesday and Thursday the next week. 4. Medical record review revealed Resident #31 was admitted to the facility on [DATE] with diagnoses including heart failure, kidney failure, chronic obstructive pulmonary disease, pneumonia, sepsis, atrial fibrillation, venous insufficiency, gastro-esophageal reflux disease, edema, laryngeal spasms, insomnia, opioid dependence, ventral hernia, pain, and anxiety. Review of handwritten care conference notes dated 03/06/25, 06/06/25, 08/13/25, and 11/11/25, revealed the resident, social service, and DON attended. On 02/11/26 the only persons in attendance were the resident and SSD. On 02/11/26 the resident had dietary changes, fluid restriction, and would like therapy services. Interview on 05/05/26 at 10:47 A.M., with Resident #31 revealed he had never attended nor had he been asked to attend a care conference. Interview on 05/07/16 at 12:53 P.M., with SSD #108 confirmed the only ones in attendance for the care conference on 03/06/25, 06/06/25, 08/13/25, and 11/11/25 was the resident, herself, and the DON. On 02/11/26 it was just herself and the resident. The IDT was aware that care conferences (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were held every Thursday. Review of the care conference policy and procedure undated revealed the physician, DON, Administrator, and Certified Nursing Assistant responsible for the individual patient, a member of the food or nutrition department, and Rehabilitation service will be invited to attend to discuss the medical condition, give input, and answer any question that may arise. Each member of the interdisciplinary team, including but not limited to MDS staff, social services, nursing, dietary, therapy, activities, as well as the primary care giver will review the medical record, visit the resident, seek out of any concerns, and assess the outcome of the last meetings recommendations prior to attending the care meeting.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to ensure resident medical were complete, accurate, and readily accessible. This affected five residents (#3, #8, #41, #47, and #48) of 21 resident records reviewed. The census was 38. Findings include:1. Record review revealed Resident #03 admitted to the facility on [DATE] with diagnoses including type 2 diabetes, schizoaffective disorder, schizoaffective disorder, major depressive disorder, generalized anxiety disorder, seizures, sleep apnea, hypertension, gastro esophageal reflux disease, bipolar disorder, and mild intellectual disabilities. Review of Resident #03 assessment for PHQ 2-9 (brief depression screener) revealed an effective date of 01/08/26, and a created date of 05/01/26. Review of Resident #03 assessment for social determinants of health revealed an effective date of 01/08/26, and a created date of 05/01/26. Review of Resident #03 Brief Interview for Mental Status BIMS evaluation revealed an effective date of 01/08/26, and a created date of 05/01/26. Interview on 05/11/26 at 12:00 P.M. with facility social service designee revealed the assessments/ evaluations for BIMS, PHQ2-9, and social determinants of health should be completed in conjunction with the resident's minimum data set, or at least quarterly. Social service designee confirmed Resident #03 assessments for BIMS. PHQ 2-9, and social determinants of health are approximately four months late and were back dated. 2. Closed medical record review revealed Resident #48 was admitted to the facility on [DATE] with diagnosis including dementia. Review hospice progress note dated 04/20/26 revealed Licensed Practical Nurse (LPN) #105 called reporting Resident #48 had passed and requested hospice nurses to make a visit to pronounce. Review of Resident #48's progress notes dated 04/20/26 revealed no evidence when staff had found resident unresponsive or hospice or family was notified. Review of Resident #48's late entry progress note dated 04/21/26 revealed the resident was confirmed dead at 10:41 P.M., by the hospice nurse. Interview on 05/05/26 at 7:28 A.M., with LPN #105 revealed the night Resident #48 had expired a Medication Tech (MT) was working on Resident #48's hall and she was assigned to the other hall. The MT asked her to come and check on the resident around 9:00 P.M., because the resident had expired. The LPN reported she could not pronounce the resident's death by herself, so she called hospice and they arrived around 10:41 P.M. to confirm the resident had expired. The LPN confirmed herself or the MT documented when they had discovered the resident or they had notified hospice or the family. 3.Closed medical record review revealed Resident #47 was admitted to the facility on [DATE] with a diagnosis of protein-calorie malnutrition. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #47's hospice note dated 02/23/26 revealed LPN #110 had called and wanted the nurse to give her a call back when she had a chance. Review of Resident #47's hospice note dated 02/23/26 revealed the resident was assessed today after the facility noted a decline. The resident appears pale, lethargic, and diaphoretic. Blood pressure hypotensive 83/42. No mottling observed. Review of Resident #47's progress notes dated 02/19/26 to 02/24/26 revealed no evidence of Resident #47 decline on 02/23/26. There were no progress notes from 02/19/26 until 02/24/26 at 5:25 A.M., when the resident was found unresponsive and pronounced dead. Interview on 05/05/26 at 7:28 A.M., with LPN #105 confirmed she had received in report that Resident #47 was passing, and his blood pressure was low. The LPN reported she had checked on the resident during the night but did not document findings. LPN #105 confirmed there was no documented evidence of the resident decline on 02/23/26 and the last documentation prior to his death on 02/24/26 was on 02/19/26. 4.Record review revealed Resident #8 admitted to the facility on [DATE] with diagnoses including end stage renal disease and hyperlipidemia. Review of a care plan dated 07/29/25 revealed Resident #8 received pain medication. The goals included to be free from any adverse reactions from pain medication through review date and pain will remain within an acceptable range through review date. Interventions included but were not limited to administer medications per physician orders, monitor for effectiveness and potential side effects, notify physician of changes; consult physician to review medication if resident has persistent side effects from medication; monitor for potential fall risks; monitor for signs and symptoms of altered mental status, anxiety, constipation, depression, dizziness, lack of appetite, nausea, vomiting, pruritis, respiratory distress, sedation, urinary retention, and notify physician of changes; monitor respiratory status after administration of pain medication as indicated; and review and assess whether pain medication is effective. Review of an order dated 02/08/26 revealed Resident #8 had oxycodone oral tablet 5 mg give one tablet by mouth every eight hours as needed for post surgery six tablets only in place. There were no parameters included in instructions for administration. Review of orders dated 02/21/24 revealed Resident #8 had oxycodone-acetaminophen 5-325 mg give one tablet by mouth every six hours as needed for pain. There were no parameters included in the instructions for administration. Review of a medication administration record (MAR) for February 2026 revealed Resident #8 received oxycodone 5 mg tablets on 02/08/26 at 1:57 P.M., 02/09/26 at 4:19 A.M. and 5:33 P.M., and on 02/18/26 at 9:09 P.M. Review of a MAR for March 2026 revealed Resident #8 received oxycodone 5 mg tablets on 03/09/26 at 4:57 P.M., 03/27/26 at 11:55 A.M., and on 03/29/26 at 5:21 P.M. Review of a MAR for May 2026 revealed Resident #8 received oxycodone 5 mg tablet on 05/01/26 at 12:04 P.M. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/07/26 at 2:21 P.M. with DON confirmed the total tablets marked on Resident #8's MARs was eight, and she was not sure how that would be possible considering the order was for a total of six tablets only. Interview on 05/11/26 at 1:03 P.M. with DON revealed nurses were accidentally signing the MAR for oxycodone instead of oxycodone-acetaminophen 5-325 mg which was a current order. DON showed the times of administration versus the times medications were signed out on the narcotic logs lined up with Resident #8 receiving the oxycodone-acetaminophen but an error in documentation. 5. Medical record review revealed Resident #41 was admitted to the facility on [DATE] with diagnoses including encephalopathy, osteomyelitis, chronic obstructive pulmonary disease, diabetes mellitus, asthma, dementia, major depression, urge incontinence, anxiety, long QT syndrome, insomnia, pain, peripheral vascular disease, Vitamin D Deficiency restless leg syndrome, gastritis, constipation, occlusion and stenosis of carotid artery, hyperglycemia, hyperlipidemia, nocturia, and hypomagnesemia. Review of the Medication Error Report Form dated 02/25/26 completed by the Director of Nursing (DON) revealed at 9:00 A.M., Resident #41 was administered the wrong medication. The Certified Medication Aide (CMA) was passing medication, and two other residents came to the medication cart wanting their morning medications. The CMA told them she would be there soon. The CMA went into the room and gave the medication to bed B instead of bed A. The incident was reported to the resident's physician, DON, and family. The corrective action taken was the five rights of medication pass was done one on one with CMA and house education was given to medication techs and nurses. How could the errors have been corrected included to practice five rights, decrease interruptions during medication pass, and facility admission staff to be cautious when resident names are close are placed in the same room. The report was signed off by the DON and Administrator on 02/25/26. Review of Resident #41 medical record dated 02/25/26 to 02/28/26 revealed no documented evidence of medication error incident that occurred on 02/25/26. Interview on 04/28/26 at 3:39 P.M., 3:45 P.M., and 04/29/26 at 7:10 A.M. and 8:21 A.M. with the Director of Nursing (DON) confirmed CMA #108 had administered Resident #49's medication to Resident #41 on 02/25/26. The DON confirmed the resident was admitted to hospice services on 02/10/26, however hospice was not notified of the medication error until 02/26/26. The DON also confirmed she notified the NP after the incident and received new orders to monitor the resident, obtain vital signs every two hours times one, then every four hours for 24 hours, and to hold sedative medication due to the resident would probably sleep all day after receiving Buprenorphine, however she never wrote the orders. Interview on 04/29/26 at 7:50 A.M., with CMA #108 confirmed she had administered Resident #49's medication to Resident #41 on 02/25/26. The CMA reported that CMAs were not permitted to notify doctors, families, representatives, assess residents, or document in the medical record. Review of the facility policy and procedure titled Medication Error Reporting and Adverse Drug Reaction Prevention and Detection dated 01/2023 revealed medication errors and adverse drug reactions are assessed, documented, and reported as appropriate to the resident's attending physician and/or prescribers, the Pharmaceutical Service Committee, the pharmacy, and Food and Drug Administration MedWatch Program or USP/ISMP Medication Error Reporting Program. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In the event of a significant medication error or adverse drug reaction, immediate action is taken, as necessary, to prevent the residents' safety and welfare. The prescriber is notified promptly of any significant error or adverse medication reactions. Any new prescriber's orders are implemented, and the resident is monitored closely for 24 to 72 hours or as directed. The incident is described on the shift change report to alert staff of the need to monitor the resident. The following information is documented in the resident's medical record and/or on the incident report: factual description of the error or adverse reaction, name of the prescriber and time notified, prescriber's subsequent orders, and residents' condition for 24 to 72 hours or as directed. Review of the facility's policy and procedure titled Status Change in Resident Condition-Notification undated revealed the facility would promptly notify the residents', his/her attending physician, and responsible party of changes in the resident's condition and/or status. The licensed nurse would notify the resident's attending physician for directive when the resident was involved in any accident/incident, a need to alter the resident's treatment significantly, or deemed necessary or appropriate in the best interest of the resident. Unless otherwise instructed by the resident, the licensed nurse would notify the resident responsible party. The licensed nurse will record in the resident's medical record any changes in the resident's medical condition or status.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of hospice records, interviews, and policy review the facility failed to ensure a resident's hospice service and medical provider were notified of a medication error and failed to ensure a resident's physician and resident representative were notified of a new skin alteration. This affected one resident (#41) of one resident reviewed for medication errors and one resident (#40) of three residents reviewed for pressure ulcers. Findings include: 1.Medical record review revealed Resident #41 was admitted to the facility on [DATE] with diagnoses including encephalopathy, osteomyelitis, chronic obstructive pulmonary disease, diabetes mellitus, asthma, dementia, major depression, urge incontinence, anxiety, long QT syndrome, insomnia, pain, peripheral vascular disease, Vitamin D Deficiency restless leg syndrome, gastritis, constipation, occlusion and stenosis of carotid artery, hyperglycemia, hyperlipidemia, nocturia, and hypomagnesemia. The resident was a full code status, and allergies included Duloxetine, Morphine, and Betadine. Review of Resident #41's admission minimum data set (MDS) assessment dated [DATE] revealed the resident observation period ended on 02/17/26 for the assessment. Resident #41 was admitted to the facility on [DATE]. The resident's brief interview for mental status (BIMS) was noted to be 13 (cognition intact). The resident had no noted behaviors or rejection of care. Resident #41's diagnoses included hypertension, peripheral vascular disease, diabetes, hyperlipidemia, non-Alzheimer's dementia, malnutrition, anxiety, depression, pressure ulcer on foot, and pulmonary disease. Review of Resident #41's plan of care dated 02/11/25 revealed the resident received hospice services related to hypertension and heart disease. Interventions included contacting hospice for changes in the resident's condition and medication as ordered. Review of the facility's investigation for Resident #41's medication error on 02/25/26 revealed the investigation included: a list of the resident's blood pressure reading printed 04/28/26, a undated handwritten list of medication names (Thiamine (Vitamin), Carvedilol (Beta-Blocker) Propranolol (antidysrhythmic/beta blocker), Lisinopril (ace-inhibitors), Ascorbic Acid (Vitamin), Aspirin (antiplatelet), Amlodipine (calcium channel blocker), Pantoprazole (proton pump inhibitors), Venlafaxine (antidepressant), Folic Acid (vitamin), Buprenorphine (opioid analgesic), Baclofen (muscle relaxer), and sennoside (stool softener). Only one medication included the dose (Thiamine 100 mg), staff education dated 02/25/25, a written medication error report form dated 02/25/26, and electronic medication error report dated 02/25/26. There was no documented evidence the resident's hospice service provider or medical provider was notified of the medication error. Review of Resident #49's (Resident #41's roommate) orders and medication administration record (MAR) dated 02/2026 revealed Amlodipine 5 mg daily for hypertension, Ascorbic acid 500 mg daily for supplement, Aspirin 81 mg daily for anti-platelet, Baclofen 20 mg three times daily for muscle spasms, Buprenorphine 8 mg sublingual three times daily for detox, Carvedilol 6.25 mg twice daily for hypertension, Folic acid 1 mg daily for anemia, Lisinopril 40 mg daily for hypertension, Pantoprazole daily for gastric reflux disease, Propranolol 120 mg daily for hypertension, Thiamine 100 mg daily for supplement, Venlafaxine 50 mg daily for depression, and Sennosides 8.6 mg one twice daily. Resident #49's diagnoses on the orders included cirrhosis of the liver, anemia, emphysema, altered mental status, constipation, opioid dependence, metabolic and toxic encephalopathy, moderate (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	protein-calorie malnutrition, paroxysmal atrial fibrillation, hypothyroidism, hypokalemia, and hypomagnesemia, Review of the Medication Error Report Form dated 02/25/26 completed by the Director of Nursing (DON) revealed at 9:00 A.M., Resident #41 was administered the wrong medication. The Certified Medication Aide (CMA) was passing medication, and two other residents came to the medication cart wanting their morning medications. The CMA told them she would be there soon. The CMA went into the room and gave the medication to bed B instead of bed A. The incident was reported to the resident's physician, DON, and family. The box was blank if it was reported to pharmacy. The corrective action taken was the five rights of medication pass was done one on one with CMA and house education was given to medication techs and nurses. How could the errors have been corrected included to practice five rights, decrease interruptions during medication pass, and facility admission staff to be cautious when resident names are close are placed in the same room. The report was signed off by the DON and Administrator on 02/25/26. There was no documented evidence hospice was notified of the medication error. Review of the electronic medication error report dated 02/25/26 at 9:00 A.M. and completed by the Assistant Director of Nursing (ADON)/Registered Nurse (RN) #117 revealed the Resident #41 had received roommate's medication with no adverse reactions noted at this time. Resident head to toe assessments completed within normal limits. The provider was notified and all medications reviewed to make sure no allergies were detected. Residents were made aware of the situation and every two hour vital signs times one, then every four hours for 24 hours initiated. Resident in agreement with plan of care. The level of consciousness, mobility, and mental status were blank. The resident was notified on 02/25/26 at 11:49 A.M., the provider at 11:28 A.M., and the DON at 11:28 A.M. There was no documented evidence hospice was notified of medication error. Review of Resident #41 medical record dated 02/25/26 to 02/28/26 revealed no documented evidence of medication error incident that occurred on 02/25/26 was documented in the medical record. In addition, there was no documented evidence hospice or the medical provider was notified of the medication error. Review of Resident #41's hospice note dated 02/26/26 authored by Chaplin #201 revealed the Chaplin was visiting and the roommate reported that Resident #41 mistakenly received his medication. The resident was confused. The Chaplin notified the hospice office via team thread. The Chaplin forgot to notify the facility at the time of his visit. The Chaplin called the facility and spoke to Licensed Practical Nurse (LPN) #100 who stated the facility was aware of the situation. Review of Resident #41's hospice note dated 02/26/26 authored by Hospice Registered Nurse (RN) #202 revealed the nurse spoke to the hospice physician about the medication error from the facility. New orders to monitor for four days. No change in medication at this time. Interview on 04/28/26 at 3:39 P.M., 3:45 P.M., and 04/29/26 at 7:10 A.M. and 8:21 A.M. with the Director of Nursing (DON) confirmed CMA #108, who was also the social service designee, admission coordinator, marketing director, CNA, and the facility's beautician, had administered Resident #49's medication to Resident #41 on 02/25/26. The DON confirmed the resident was admitted to hospice services on 02/10/26, however hospice was not notified of the medication error until 02/26/26. The DON also confirmed she notified the NP after the incident and received new orders to monitor the resident, obtain vital signs every two hours times one, then every four hours for 24 hours, and to hold sedative medication due to the resident would probably sleep all day after receiving Buprenorphine, (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	however she never wrote the orders. Interview on 04/29/26 at 7:50 A.M., with CMA #108 confirmed she had administered Resident #49's medication to Resident #41 on 02/25/26. The CMA reported that CMAs were not permitted to notify doctors, families, representatives, assess residents, or document in the medical record. Interview on 04/29/26 at 9:00 A.M., with Assistant Director of Nursing (ADON)/ Registered Nurse (RN) #117 confirmed she had spoken to Resident #41 the day of the medication error and he didn't want his wife called because she would think it was his fault. The resident was his own responsible party, but his cognition had really declined after the incident. The ADON confirmed there was no documented evidence hospice was notified of the medication error. Interview on 04/29/26 at 9:41 A.M., with NP #200 confirmed she had just taken over as the NP for the facility around the time of medication error involving Resident #41. The NP confirmed she had spoken to the DON and had given verbal order to monitor the resident, which would include orientation, if he was lethargic, not eating, behaviors changes, etc. The NP reported she was not notified he had slept all day, or his pulse had dropped below 60 beats per minute (normal 60-90 beats per minute). The NP confirmed the resident had received a beta-blocker and a pulse rate below 60 would be concerning. The NP confirmed her expectations would have been to be notified of the lethargy and pulse rate below 60 and she would have sent him to the hospital for evaluation. The NP reported that she doesn't recall telling the DON to hold sedative medications and confirmed the resident was not seen by a provider after the medication error and typically a resident would have been seen at the next visit, which would have been Friday 02/27/26, and she would have taken full ownership that he was not seen. The NP reported she was not aware of the resident's continued decline in mental status and he had not been seen by a provider since 02/20/26 and she had never seen the resident since she started in February. Review of the facility assessment dated 01/2026 revealed the staffing was based on resident population and acuity. Nursing services included: e.g. DON, RN, LPN, Certified Nursing Assistants (CNA), and Minimum Data Set (MDS) nurse. The assessment didn't indicate CMA. Staff competencies included medication administration in the fourth quarter (October, November, and December). Review of the facility policy and procedure titled Medication Error Reporting and Adverse Drug Reaction Prevention and Detection dated 01/2023 revealed medication errors and adverse drug reactions are assessed, documented, and reported as appropriate to the resident's attending physician and/or prescribers, the Pharmaceutical Service Committee, the pharmacy, and Food and Drug Administration MedWatch Program or USP/ISMP Medication Error Reporting Program. In the event of a significant medication error or adverse drug reaction, immediate action is taken, as necessary, to prevent the residents' safety and welfare. The prescriber is notified promptly of any significant error or adverse medication reactions. Any new prescriber's orders are implemented, and the resident is monitored closely for 24 to 72 hours or as directed. The incident is described on the shift change report to alert staff of the need to monitor the resident. The following information is documented in the resident's medical record and/or on the incident report: factual description of the error or adverse reaction, name of the prescriber and time notified, prescriber's subsequent orders, and residents' condition for 24 to 72 hours or as directed. Review of the facility's policy and procedure titled Status Change in Resident Condition-Notification undated revealed the facility would promptly notify the residents', his/her attending physician, and (continued on next page)

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Muskingum Skilled Nursing & Rehabilitation	501 Pinecrest Drive Beverly, OH 45715

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible party of changes in the resident's condition and/or status. The licensed nurse would notify the resident's attending physician for directive when the resident was involved in any accident/incident, a need to alter the resident's treatment significantly, or deemed necessary or appropriate in the best interest of the resident. Unless otherwise instructed by the resident, the licensed nurse would notify the resident responsible party. The licensed nurse will record in the resident's medical record any changes in the resident's medical condition or status. 2. Record review revealed Resident #40 was admitted to the facility on [DATE] with diagnoses including hypoglycemia, type 2 diabetes, dysphagia, benign prostatic hyperplasia, heart failure, major depressive disorder, insomnia, hallucinations, osteoarthritis, and mood disorder. Review of Resident #40's quarterly minimum data set (MDS) completed on 02/11/26 revealed a brief interview for mental status (BIMS) score of 06 indicating severe cognitive impairment and no displayed behaviors. The resident utilized a wheelchair for mobility, required supervision/ touching assistance for eating, toileting hygiene, upper body dressing, lower body dressing, putting on and taking off footwear, and personal hygiene. The resident required set up or clean up assistance for oral hygiene. The resident was occasionally incontinent of urine and frequently incontinent of bowel. The resident had a therapeutic diet ordered (low salt, low cholesterol, and diabetic). The resident had not had a weight loss of 5% or more in the last month or loss of 10% or more in last 6 months. The resident was not at risk of developing pressure ulcers/injuries and had no active skin problems. Review of Resident #40's progress note for clinical admission dated 04/30/26 at 5:00 P.M. revealed the resident had a stage two pressure ulcer (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister) to the sacrum with a 5 centimeter (cm) circular non blanchable area with a small open area of 0.1 centimeters (cm) in length, 0.1cm in width, and 0.1 cm in depth. Review of Resident #40 progress note dated 04/30/26 at 5:00 P.M. revealed a note which stated the resident returned form the hospital via ambulance with two attendants on gurney. Resident transferred to bed with two assist. Daughter made aware of return to facility. Interview on 05/11/26 at 1:40 P.M. with the Assistant Director of Nursing confirmed there was no documentation in the resident's medical record of Resident #40's representative or physician being notified of the new alteration in the resident's skin integrity. Review of facility policy titled Wound Care Management (dated 02/2023) revealed if a new skin area is identified the physician and responsible party will be notified promptly of the newly identified skin area and a treatment. Review of the undated facility policy titled Status Change in Resident Condition revealed the licensed nurse will record in the resident's medical record any changes in the resident's medical condition or status. The facility will promptly notify the resident, his/her attending physician, and responsible party of changes in the resident's condition and/or status. This deficiency represents non-compliance investigated under Complaint Number 2800245.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, interview, and policy review, the facility failed to provide the Notice of Medicare non coverage (NOMNC) to Medicare beneficiaries at least two days before the end of a Medicare covered part A stay. This had the potential to affect one (Resident #50) of three residents reviewed for Notice of Medicare non coverage. The census was 48.Findings Include: Closed record review revealed Resident #50 admitted to the facility on [DATE] with diagnoses including type two diabetes, chronic obstructive pulmonary disorder, nicotine dependence, major depressive disorder, generalized anxiety disorder, obstructive sleep apnea, atrial fibrillation, and hypertension.Review of Resident #50's Beneficiary protection notification revealed the residents last covered day of part A services was 11/11/25.Review of Resident #50 Beneficiary protection notification revealed the resident had been notified that coverage of services would end on the date on the notice [11/11/25] and that they could appeal this decision, the form was signed and dated by Resident #50 on 11/10/25.Interview on 05/12/26 at 12:36 P.M. with Social Service Designee #108 confirmed Resident #50's last covered day of part A services was 11/11/25 and the resident was provided the notice on 11/10/25.Review of the undated facility policy titled Form instructions for the in NOMNC revealed a Medicare health provider must give an advance, completed copy of the notice of Medicare non coverage to enrollees receiving skilled nursing, home health, or comprehensive outpatient rehabilitation facility services, no later than two days before the termination of services.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview, the facility failed to ensure a shared resident bathroom was maintained in a sanitary manner. This affected one (Resident #31) of two resident's reviewed for environment. Findings Include: Interview on 04/28/26 at 2:52 P.M., 04/29/26 at 12:40 P.M., and 05/05/26 at 10:23 A.M., with Resident #31 revealed he had to share a bathroom with the room next door, and one of the male residents next door urinated and had bowl movements all over the bathroom and did not flush the toilet. Resident #31 shared photos from his phone of the unsanitary condition of the bathroom. The photos confirmed there was urine and bowel movements on the floors and toilet, and the toilet was not flushed. Interview on 05/13/26 at 9:21 A.M., with Housekeeping Supervisor (HKS) #113 confirmed Resident #31 had voiced concerns related to the male resident that shared a bathroom with him, missing the toilet when he urinated and he didn't flush. She stated the housekeeping staff cleaned all residents' bathrooms daily and upon request, which Resident #31 had requested additional cleanings of the bathroom in the past. Random tour of resident bathrooms on 05/13/26 at 9:28 A.M., with Maintenance Director revealed Resident #31's bathroom had urine on the floor, urine on the toilet rim, and the toilet had not been flushed. The Maintenance Director confirmed the findings during the observation. This deficiency represents non-compliance investigated under Complaint Number 2961731.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of self-reported incident, review of concern log, observation, interview, and policy review, the facility failed to ensure an allegation of misappropriation was reported timely to the state agency. This affected one (Resident #41) of three reviewed for personal property. Findings Include: Medical record review revealed Resident #41 was admitted to the facility on [DATE] with diagnoses including encephalopathy, osteomyelitis, chronic obstructive pulmonary disease, diabetes, obesity, depression, anemia, long QT syndrome, anxiety, pain, peripheral vascular disease, Vitamin D deficiency, restless legs syndrome, gastritis, constipation, occlusion and stenosis, hypomagnesemia, hyperglycemia, hyperlipidemia, and nocturia. Review of the concerns log dated 01/2026 to 05/2026 revealed there were no concerns that were reported in the last five months, including a missing wallet for Resident #41.Interview on 05/05/26 at 11:54 A.M., with Resident #41's wife revealed two or three weeks after Resident #41 was admitted his wallet came up missing. The wallet contained a credit card and a driver's license. Interview on 05/06/26 at 8:58 A.M., with the Administrator revealed she was not aware Resident #41 wallet was missing. The surveyor reported to the Administrator that Resident #41's wife had reported during a family interview her husband's wallet, containing a credit card and a driver's license, had been missing two or three weeks after he had been admitted . Observation on 05/06/26 at 8:58 A.M., of Resident #41's room with the Administrator confirmed there was no evidence of a wallet in the resident's room. The resident had noted cognition impairment and reported maybe his wife had his wallet. Interview on 05/06/26 at 9:00 A.M., with the Director of Nursing (DON) revealed she was not aware Resident #41's wallet was missing. Interview on 05/06/26 at 9:50 A.M., with Social Service Designee (SSD) #108 revealed she was unaware Resident #41's wallet was missing. The SSD reported Resident #41 had a roommate in February 2026, however he was discharged and went to New York. Interview on 05/06/26 at 9:55 A.M., with Resident #41's sister confirmed Resident #41's wife had reported to her back in February 2026 that Resident #41's wallet was missing and Resident #41's wife had reported the wallet missing to staff. Resident #41's sister confirmed the contents of the wallet. Follow-up interview on 05/06/26 at 10:11 A.M., with Resident #41's wife confirmed she has reported the missing wallet in February 2026 to Certified Nurses' Aide (CNA) #132 and a male staff member. The staff had looked for the wallet but were not able to locate it. Resident #41's wife confirmed she had a friend cancel the credit card, but the resident still didn't have a driver's license. Review of a typed statement authored by the Administrator dated 05/06/26 revealed the Administrator had spoken with Resident #41's wife asking if she knew of the missing wallet. The wife stated that he had a camo wallet that he was unable to find but was still looking for it. Interview on 05/11/26 at 1:21 P.M., with the Administrator revealed she did not initiate an SRI for Resident #41's missing wallet, credit card, and driver's license due to Resident's #41's wife didn't indicate the wallet was stolen and it was only missing. The Administrator reported she would offer to replace the wallet and take the resident to the Bureau of Motor Vehicle (BMV) to obtain a new driver's license. The Administrator confirmed she had spoken to Resident #41's sister last week to confirm the wallet was missing. An additional statement was obtained on 05/11/26 and authored by the Administrator with Resident #41's wife revealed the wallet contained one credit card, his driver's license and a picture of her. The statement indicated that management was not notified, however the statement did not include the two staff members names that the wallet was reported missing to, back in February when it was discovered missing. Review of undated statement authored by the Administrator revealed LPN #102 reported he had not seen the wallet; however, the wife had mentioned it. There was no additional details or information regarding what the wife had mentioned to LPN #102. Interview on 05/12/26 at 7:50 A.M., with the Administrator confirmed she still had not initiated an SRI because she had spoken to Resident #41's wife and didn't feel anyone had taken the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wallet and she just wanted the facility to replace the wallet. The Administrator confirmed she had not completed an investigation except she had interviewed a few staff members. The surveyor had requested the interviews. The Administrator returned with the some typed and some written interviews dated 05/06/26, 05/11/26, 05/12/26, and some were not dated. The Administrator confirmed Resident #41's wife confirmed she had reported the missing wallet to CNA #132 and Licensed Practical Nurse (LPN) #102 however the Administrator confirmed she didn't include that information in her typed statement on 05/11/26. The Administrator reported the wife never reported the wallet missing to management. The Administrator reported she had not been able to interview CNA #132 at this time. Review of the self-reported incidents (SRI) dated 01/2026 to 05/2026 revealed no evidence the facility had initiated a self-reported incident for Resident #41's missing wallet that contained a credit card and driver's license in February 2026 when the wife reported she had reported the wallet missing nor on 05/06/26 when the State Surveyor had reported the missing wallet with a credit card and the residents driver's license to the Administrator, DON, and SSD. The facility initiated the SRI on 05/12/26 at 8:07 A.M. and indicated on 05/06/26 it was reported that Resident #41 had a missing wallet, that the surveyor notified the facility administrator, but the family did not. Review of the facility's undated policy and procedure titled Abuse Prohibition revealed residents would not be subjected to abuse, neglect, exploitation, mistreatment, misappropriation of property by anyone. Any reports or investigation will be reviewed by and conducted through the Quality Committee. A thorough investigation of all alleged violations will be conducted. Any alleged allegations are to be communicated immediately to the Administrator or designee. The investigation procedure begins immediately by the Administrator of facility designee. Reporting of all allegations not involving abuse or serious bodily injuries must not exceed 24hours. The results of a thorough investigation of the allegations will be reported to the department of health within five working days of the incident.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of concern log, review of self-reported incident, observation, interview, and policy review, the facility failed to timely investigate an allegation of misappropriation of a resident's wallet. This affected one (Resident #41) of three reviewed for personal property. Findings Include: Medical record review revealed Resident #41 was admitted to the facility on [DATE] with diagnoses including encephalopathy, osteomyelitis, chronic obstructive pulmonary disease, diabetes, obesity, depression, anemia, long QT syndrome, anxiety, pain, peripheral vascular disease, Vitamin D deficiency, restless legs syndrome, gastritis, constipation, occlusion and stenosis, hypomagnesemia, hyperglycemia, hyperlipidemia, and nocturia. Review of the concerns log dated 01/2026 to 05/2026 revealed there were no concerns that were reported in the last five months, including a missing wallet for Resident #41.Interview on 05/05/26 at 11:54 A.M., with Resident #41's wife revealed two or three weeks after Resident #41 was admitted his wallet came up missing. The wallet contained a credit card and a driver's license. Interview on 05/06/26 at 8:58 A.M., with the Administrator revealed she was not aware Resident #41 wallet was missing. The surveyor reported to the Administrator that Resident #41's wife had reported during a family interview her husband's wallet, containing a credit card and a driver's license, had been missing two or three weeks after he had been admitted . Observation on 05/06/26 at 8:58 A.M., of Resident #41's room with the Administrator confirmed there was no evidence of a wallet in the resident's room. The resident had noted cognition impairment and reported maybe his wife had his wallet. Interview on 05/06/26 at 9:00 A.M., with the Director of Nursing (DON) revealed she was not aware Resident #41's wallet was missing. Interview on 05/06/26 at 9:50 A.M., with Social Service Designee (SSD) #108 revealed she was unaware Resident #41's wallet was missing. The SSD reported Resident #41 had a roommate in February 2026, however he was discharged and went to New York. Interview on 05/06/26 at 9:55 A.M., with Resident #41's sister confirmed Resident #41's wife had reported to her back in February 2026 that Resident #41's wallet was missing and Resident #41's wife had reported the wallet missing to staff. Resident #41's sister confirmed the contents of the wallet. Follow-up interview on 05/06/26 at 10:11 A.M., with Resident #41's wife confirmed she has reported the missing wallet in February 2026 to Certified Nurses' Aide (CNA) #132 and a male staff member. The staff had looked for the wallet but were not able to locate it. Resident #41's wife confirmed she had a friend cancel the credit card, but the resident still didn't have a driver's license. Review of a typed statement authored by the Administrator dated 05/06/26 revealed the Administrator had spoken with Resident #41's wife asking if she knew of the missing wallet. The wife stated that he had a camo wallet that he was unable to find but was still looking for it. Interview on 05/11/26 at 1:21 P.M., with the Administrator revealed she did not initiate an SRI for Resident #41's missing wallet, credit card, and driver's license due to Resident's #41's wife didn't indicate the wallet was stolen and it was only missing. The Administrator reported she would offer to replace the wallet and take the resident to the Bureau of Motor Vehicle (BMV) to obtain a new driver's license. The Administrator confirmed she had spoken to Resident #41's sister last week to confirm the wallet was missing. An additional statement was obtained on 05/11/26 and authored by the Administrator with Resident #41's wife revealed the wallet contained one credit card, his driver's license and a picture of her. The statement indicated that management was not notified, however the statement did not include the two staff members names that the wallet was reported missing to, back in February when it was discovered missing. Review of undated statement authored by the Administrator revealed LPN #102 reported he had not seen the wallet; however, the wife had mentioned it. There was no additional details or information regarding what the wife had mentioned to LPN #102. Interview on 05/12/26 at 7:50 A.M., with the Administrator confirmed she still had not initiated an SRI because she had spoken to Resident #41's wife and didn't feel anyone had taken the wallet and she just wanted the facility to replace the wallet. The Administrator confirmed she had not (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed an investigation except she had interviewed a few staff members. The surveyor had requested the interviews. The Administrator returned with the some typed and some written interviews dated 05/06/26, 05/11/26, 05/12/26, and some were not dated. The Administrator confirmed Resident #41's wife confirmed she had reported the missing wallet to CNA #132 and Licensed Practical Nurse (LPN) #102 however the Administrator confirmed she didn't include that information in her typed statement on 05/11/26. The Administrator reported the wife never reported the wallet missing to management. The Administrator reported she had not been able to interview CNA #132 at this time. Review of the self-reported incidents (SRI) dated 01/2026 to 05/2026 revealed no evidence the facility had initiated a self-reported incident for Resident #41's missing wallet that contained a credit card and driver's license in February 2026 when the wife reported she had reported the wallet missing nor on 05/06/26 when the State Surveyor had reported the missing wallet with a credit card and the residents driver's license to the Administrator, DON, and SSD. The facility initiated the SRI on 05/12/26 at 8:07 A.M. and indicated on 05/06/26 it was reported that Resident #41 had a missing wallet, that the surveyor notified the facility administrator, but the family did not. The investigation noted the facility immediately spoke with the residents family, and there were no immediate concerns for misappropriation though a comprehensive investigation was to follow. Review of the facility's undated policy and procedure titled Abuse Prohibition revealed residents would not be subjected to abuse, neglect, exploitation, mistreatment, misappropriation of property by anyone. Any reports or investigation will be reviewed by and conducted through the Quality Committee. A thorough investigation of all alleged violations will be conducted. Any alleged allegations are to be communicated immediately to the Administrator or designee. The investigation procedure begins immediately by the Administrator of facility designee. Reporting of all allegations not involving abuse or serious bodily injuries must not exceed 24hours. The results of a thorough investigation of the allegations will be reported to the department of health within five working days of the incident.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview the facility failed to ensure a resident had an individualized trauma informed plan of care. This affected one resident (#28) of four residents reviewed for behaviors.FIndings include: Record review of Resident #28's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including personality disorder, depression, generalized anxiety, post-traumatic stress disorder (PTSD), personal history of suicidal behavior, poisoning by benzodiazepines, and sedative, hypnotic or anxiolytic dependence, in remission. Review of Resident #28's psychiatric note dated [DATE] revealed the resident had PTSD and was stable on Zoloft (anti-depressant) and Xanax (anti-anxiety). The resident had PTSD from watching a friend wreck and die on motorcycle when she was younger and it plays back in her head. She had attempted suicide. There was no documented evidence of triggers or individualized intervention. Review of Resident #28's quarterly psychosocial/behavioral assessment dated [DATE] revealed the resident had PTSD. The assessment did not include triggers or individualized interventions. Review of Resident #28's risk for impaired social interaction related to history of trauma plan of care dated [DATE] revealed (triggers) the resident had a really good friend being killed, son not wanting anything to do with her, PTSD, and history of suicidal behavior. The intervention included to encourage positive communication with others, verbalizing feelings, medication per order, notify physician of decline, offer psych services, provide positive reinforcements, refer to counseling/psychiatry, social to provide education regarding outpatient community resources and support groups, set up as indicated. There was no evidence of triggers or individual interventions. Interview on [DATE] at 9:17 A.M., with Resident #28 revealed she had PTSD related to a combination of life events. She had watched a friend wreck a motorcycle in front of her and expired, a few months later her house burnt down with her pets inside and she lost everything and she had been in bad relationship. She had been having panic attacks and has not been sleeping well since she was taken off Xanax almost a year ago. She was seen by the in-house psychiatrist, but he yelled at her, so she fired him. The resident reported triggers for PTSD included the sound of motorcycles, loud noises, and certain words. Interview on [DATE] at 11:04 A.M. and 1:47 P.M., with Social Service Designee (SSD) #108 confirmed Resident #28 did not have a comprehensive PTSD assessment or comprehensive care plan for PTSD to include triggers or individualized interventions. The SSD reported she knew the resident prior to becoming a resident at the facility. The resident watched a close friend get killed on a motorcycle and another one got shot and killed five years later. She doesn't talk a lot about it and shuts down. She refused to see a psychologist and she would have to look to see if anyone had been following her psychological needs. The SSD didn't know what the resident triggers for the PTSD included.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, and policy review, the facility failed to ensure residents who were dependent on staff were provided assistance with personal hygiene and bathing. This affected two residents (#19 and #25) of four residents reviewed for activities of daily living. The facility census was 38. Findings include:1.Record review revealed Resident #19 admitted to the facility on [DATE] with diagnoses including end stage renal disease and atrial fibrillation. Review of a care plan dated 12/19/23 revealed Resident #19 required assistance with ADLs related to debility and weakness. The goals included to continue to participate in ADLs as able and have no decline in ADLs through review; remain clean, dry, odor free and appropriately dressed through the review; and remain well-groomed and free of odors at all times and will participate in ADL self-care. Interventions included but were not limited to staff to adjust care as needed to meet resident's needs; staff to encourage resident to participate in ADLs during care; and staff will assist as needed with daily hygiene and will assist with showering resident as per facility policy. Review of a minimum data set (MDS) dated [DATE] revealed Resident #19's cognition remained intact, had no behaviors, and was dependent on staff for personal hygiene. Observation on 05/05/26 at 7:53 A.M. revealed Resident #19 was resting in bed and her nails were long with a dark brown substance underneath. Observation on 05/05/26 at 1:31 P.M. revealed Resident #19 was seated in her wheelchair and had long, dark brown nails and long chin hairs. Interview on 05/06/26 at 6:54 A.M. with Certified Nursing Assistant (CNA) #145 confirmed Resident #19's fingernails were long and had a dark brown substance underneath. CNA #145 stated Resident #19 is often scratching her arms which may cause that. CNA #145 also confirmed Resident #19 had chin hair but stated she had an electric shaver she was able to use by herself. Resident #19 was awake at the time of the interview and stated her nails needed taken care of, but she would often do them herself. 2. Record review revealed Resident #25 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, type two diabetes mellitus, malnutrition, amnesia, abdominal aortic aneurysm, depression, and gastro esophageal reflux disease. Review of Resident #25's Medicare 5 day minimum data set (MDS) completed on 04/16/26 revealed a brief interview for mental status (BIMS) score of 14. A total severity score of 05, no displayed behaviors. The resident required dependence on staff for oral hygiene, toileting, showering and bathing, upper and lower body dressing, putting on and taking off footwear, and dependence for transfers and mobility. The resident was always incontinent of bowel and bladder. Observation on 05/04/26 at 9:22 A.M. revealed the resident appeared unkempt wearing a white shirt with food and spilt items on it, long dirty finger nails, and no pants on. Review of Resident #25's record revealed no shower sheets, or documentation of the resident receiving and/or refusing to be showered/bathed for the month of May 2026. (continued on next page)

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Muskingum Skilled Nursing & Rehabilitation	501 Pinecrest Drive Beverly, OH 45715

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/14/26 at 2:17 P.M. with the director of nursing confirmed there was no evidence Resident #25 had received any showers for May 2026.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, interview, and policy review, the facility failed to ensure alternating air mattresses were on the correct setting to prevent pressure ulcers. This affected one resident (#19) of three residents reviewed for pressure ulcers and interventions. The facility census was 38. Findings include:Record review revealed Resident #19 was admitted to the facility on [DATE] with diagnoses including end stage renal disease and atrial fibrillation. Review of a care plan dated 10/24/21 revealed Resident #19 was at risk for impaired skin integrity related to decreased mobility, periods of bowel and bladder incontinence, bilateral lower extremity edema, oxygen per nasal cannula, history pressure ulcers, and prefers to lay on back. The goals were for excoriation will resolve without complication as occurrence arises and skin will be free of breakdown. Interventions included but were not limited to elevate heels off mattress, heel protectors as tolerated, inspect skin during daily care, lotion to skin as needed, low air loss mattress to bed, and pressure reduction devices if ordered. Review of orders revealed Resident #19 had an order in place dated 10/01/25 to ensure bed is on level four every shift and as needed. Observation on 05/05/26 at 7:51 A.M. revealed Resident #19's air mattress was set to level five. Observation on 05/05/26 at 1:31 P.M. revealed Resident #19's air mattress was set to level five. Interview on 05/06/26 at 6:45 A.M. with Maintenance Director (MD) #112 confirmed Resident #19's air mattress was set to level five. Interview on 05/06/26 at 6:54 A.M. with Certified Nursing Aide (CNA) #145 confirmed Resident #19's air mattress was set to level five. Review of an undated policy titled Pressure Ulcer Prevention Intervention revealed the policy of the facility is to implement preventative skin measures for all residents based on the levels and areas of risk to include moisture, nutrition, activity, mobility, mental status, psychosocial status, and general physical condition. When the interdisciplinary team is considering interventions, facility policy, standard of practice, and resident goals/preferences/advanced directives should be reviewed and considered prior to implementation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, review of infection control log, review contingency medication list, and interview the facility failed to ensure an urinalysis was collected timely and antibiotics were administered per order to treat urinary tract infection. This affected one resident (#48) of five residents reviewed for urinary tract infections.Findings include:Closed medical record review revealed Resident #48 was admitted to the facility on [DATE] with diagnoses including dementia, anemia, scoliosis, and ulcerated proctitis. Review of Resident #48's annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was always incontinent of urine. Review of Resident #48's alteration in elimination related to incontinent of bowel and bladder dated [DATE] and cancelled [DATE] revealed to administer all treatments per order and monitor for signs and symptoms of urinary tract infections: foul smelling urine, cloudy urine, sediment, decreased output. Notify physician of changes. Review of Resident #48's urinary tract infection plan of care dated [DATE] and cancelled [DATE] revealed to administer antibiotics per physician orders, obtain and monitor labs per orders. a. Review of Resident #48's progress note dated [DATE] (Friday) revealed the hospice nurse was updated on foul smelling dark urine. New order for urinalysis, if unable to obtain Monday morning, attempt next morning. There was no evidence that the urinalysis was attempted to be collected or collected on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], or [DATE] nor were there any assessments/signs or symptoms of the resident's urine/urinary tract infection. Review of a progress note dated [DATE] revealed urine was collected using aseptic technique via straight catheterization. The resident tolerated well and urine was labeled and placed in biohazard fridge with requisition paper inside the bag for pick up in the morning of [DATE]. Review of Resident #48's urinalysis and culture and sensitivity revealed the resident's urine was collected on [DATE], received on [DATE], and reported on [DATE]. The urine culture showed greater than 100,000 CFU/ml Escherichia Coli and Extended-spectrum beta-lactamases (ESBL) and was sensitive to Macrobid. Review of progress note dated [DATE] revealed hospice was notified of urinalysis results and requested to be faxed to them. Review of progress note dated [DATE] revealed the hospice nurse was notified of positive urinalysis culture and sensitivity. Nurse to review and return call to the facility. Review of a progress note dated [DATE] revealed new orders received from hospice physician for Macrobid (antibiotic) twice a day for seven days. Review of Resident #48's orders dated [DATE] revealed Macrobid 100 milligrams (mg) two times a day for seven days (14 doses) for urinary tract infection. Review of Resident #48's medication administration record (MAR) dated 03/2026 and 04/2026 revealed the resident only received 13 doses of Macrobid from [DATE] to [DATE]. The first dose on [DATE] was not administered and was coded 9 (see nurses note). Review of Resident #48's progress note dated [DATE] revealed no evidence of why the Macrobid was not administered on [DATE]. Review of a handwritten list of medications in the medication contingency box (undated) revealed Macrobid 100 mg was available. Review of Resident #48's McGeer Criteria for Infection Surveillance dated [DATE] revealed the resident had acute dysuria, suprapubic pain, new or marked increase of urgency and frequency, and greater than 100,000 cfu/ml of any organism and met criteria of a urinary tract infection. Review of Resident #48's antibiotic time-out form completed by the physician dated [DATE] revealed the resident was ordered Macrobid on [DATE] and McGeer's criteria for treatment. b. Review of Resident #48's orders dated [DATE] revealed orders for urinalysis. Review of Resident #48's progress notes dated [DATE] to [DATE] revealed no evidence the resident had signs or symptoms of urinary tract infection. Review of progress note dated [DATE] revealed straight catheterization for urine completed. Urine specimen in the refrigerator. Resident tolerated procedure well. Review of Resident #48's urinalysis and culture revealed the urine was collected on [DATE], received on [DATE], and reported on [DATE]. The urine culture showed (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	greater than 100,000 CFU/ml Escherichia Coli and Extended-spectrum beta-lactamases (ESBL). Review of hospice note dated [DATE] revealed the resident continues to have dark, foul-smelling urine despite finishing a round of antibiotics. Review of progress note dated [DATE] revealed the resident was placed on last moments by hospice. Review of progress note dated [DATE] revealed hospice confirmed resident had expired at 10:41 P.M. Review of the infection control log dated 04/2026 revealed no evidence Resident #48 was documented on the log. Interview on [DATE] at 1:42 P.M., with Registered Nurse (RN)/ Infection Preventionist (IP) #117 confirmed Resident #48 urinalysis was ordered on [DATE] and not collected until [DATE], which was not timely. The RN/IP confirmed the lab was at the facility every day except Saturday and Sunday at that time. The RN/IP confirmed that the first dose of Macrobid was not administered on [DATE] as ordered nor was the order extended to ensure the resident received all 14 doses. RN/IP #117 confirmed Macrobid was available in the contingency box. The RN/IP confirmed that a Medication Technician (MT) had marked on the MAR on [DATE] to see documentation why the Macrobid was not administered, however there was nothing documented. RN/IP #117 also confirmed that the second urinalysis was ordered on [DATE] and not collected until [DATE], which was not timely collected as well. RN/IP confirmed the second urinalysis results were not documented on the infection control log nor was the resident treated due to the resident having expired on [DATE]. Interview on [DATE] at 2:09 P.M. with MT #133 confirmed she did not administer Resident #48's first dose of Macrobid on [DATE] due to the medication not being delivered via pharmacy. The MT reported the facility instructs the MT to chart 9 see nurses note, however MT's were not permitted to chart. The MT reported she was not sure if Macrobid was in the contingency box. The MT reported she told the nurse she didn't administer the Macrobid and it was the nurse's responsibility to document, modify order, and to follow up on the medication.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, laboratory test review, review of education material from the Cleveland Clinic, and policy review, the facility failed to ensure appropriate interventions were implemented for a resident with weight loss and compromised nutritional status. This affected one resident (#40) of three residents reviewed for nutrition. The census was 38.Findings include: Record review revealed Resident #40 was admitted to the facility on [DATE] with diagnoses including hypoglycemia, type 2 diabetes, dysphagia, benign prostatic hyperplasia, heart failure, major depressive disorder, insomnia, hallucinations, osteoarthritis, and mood disorder.Review of Resident #40's care plan initiated 08/09/25 revealed the resident was at risk for alteration in nutrition and hydration related to diabetes, and mechanically altered diet. Goals included the resident will be adequately nourished with no significant weight changes.Review of Resident #40's record revealed an order placed on 09/01/25 for monthly weights.Review of Resident #40's quarterly minimum data set (MDS) assessment completed on 02/11/26 revealed a brief interview for mental status (BIMS) score of 6, a total severity score of 2, and no displayed behaviors. The resident utilized a wheelchair for mobility, supervision/ touching assistance for eating toileting hygiene, upper body dressing, lower body dressing, putting on and taking off footwear, and personal hygiene, set up or clean up assistance for oral hygiene. The resident was occasionally incontinent of urinary and frequently incontinent of bowel. The resident had a therapeutic diet ordered (low salt, low cholesterol, and diabetic). The resident had not had a weight loss of 5% or more in the last month or loss of 10% or more in last 6 months. The resident was not at risk of developing pressure ulcers/injuries and had no active skin problems. Review of the resident's Braden scale for predicting pressure ulcer evaluation completed 04/07/26 revealed a score of 17 indicating the resident was at risk for skin break down. Review of Resident #40's nutritional evaluation completed 04/09/26 revealed the resident had a weight loss of 5% or more in the last month or loss of 10% or more in 6 months with inadequate protein and oral intake, and altered nutrition related to labs. The resident was at nutritional risk related to type 2 diabetes mellitus, significant weight loss, and poor PO intake. Resident #40's estimated caloric intake needs included 2,455 calories, and 98 grams of protein.Review of Resident #40's weight record revealed on 01/07/26 the resident weighed 226.0 pounds (lbs). On 02/04/26 the resident weighed 229.6 lbs. On 03/04/26 the resident weighed 228.4 lbs. On 04/08/26 the resident weighed 216.0 lbs. On 04/15/26 the resident weighed 204.6 lb. On 04/22/26 the resident weighed 199.6 lbs. On 05/06/26 the resident weighed 195.0 lbs.Record review revealed Resident #40 had a 13.72% weight loss over five months.Review of Resident #40's laboratory work completed on 03/18/26 revealed an albumin level of 3.3 grams per deciliter (g/dl) [normal range 3.5-5.5 g/dl].Review of Resident #40's laboratory work completed on 04/02/26 revealed an albumin level of 2.5 g/dl [normal range 3.5-5.5 g/dl].Review of Resident #40's meal intake record revealed for 04/08/26 through 05/05/26 there was no documentation of 23 different meals. Of the 78 meals served to the resident , 55 meals had documented intakes. 26 meals served to Resident #40 had 0-25% consumed, 13 meals had 26-50% consumed, the resident refused seven meals.Record review revealed an order placed on 04/10/26 for house supplement juice drink 237 milliliters (ml) three times a day (TID) for supplement, 250 calories and nine grams of protein per 237 ml.Record review revealed an order placed on 04/10/26 for Remeron (appetite stimulant) oral tablet 15 milligrams (mg).Record review revealed an order placed on 04/22/26 for reduced carbohydrate diet, mechanical soft with fortified foods to all meals.Review of Resident #40's skin grid for pressure ulcers completed on 04/30/26 revealed the resident had a new pressure ulcer to the coccyx present upon readmission. Resident #40 had a Stage 2 pressure ulcer that measured 0.1cm in length, 0.1 cm in width, and 0.1 cm in depth. The wound had 100% granulation tissue with no drainage.Review of Resident #40's skin grid for pressure ulcer completed on 05/07/26 revealed the resident had a Stage 2 pressure ulcer to the coccyx with partial-thickness measuring 4.5 cm in length, (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.5 cm in width, and 0.1 cm in depth with 100% granulation tissue.Interview on 05/12/26 at 9:26 A.M. with the facility dietician revealed the facility holds a monthly nutritional risk meeting with different members of the interdisciplinary team. In these meetings they review weight loss, significant weight loss, new wounds, worsening wounds, tube feeds, and dialysis. The dietician stated Resident #40 has had significant weight loss and thought he was getting weekly weights. The dietician confirmed the order was for monthly weights. Facility dietician stated the last risk meeting for Resident #40 was on 04/06/26. Dietician stated they were not made aware Resident #40 had developed a new pressure ulcer.Review of education published from the Cleveland Clinic (https://my.clevelandclinic.org/health/diagnostics/22390-albumin-blood-test)updated 12/10/24 revealed albumin is protein in the blood plasma. Albumin levels can indicate underlying nutritional deficits, for example if someone is not getting enough protein. Lower than normal albumin levels in the blood may be a sign of poor nutrition.Review of undated facility policy title weight policy and procedure revealed any weight variance (increase or decrease) of three pounds in one week or three pounds in one month must be reweighed within 24 hours. All weights and reweights must be recorded on the resident weight sheet found in the weight book. All recorded weights must be initiated and dated by the person recording the weight.Review of undated facility policy titled pressure ulcer prevention intervention revealed hydration status needs monitored, consult the registered dietician as needed. If the resident who is well-nourished develops an inadequate dietary intake of protein and calories, a nutritional assessment should be completed by the registered/ licensed dietician.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interviews, and policy review the facility failed to administer oxygen to residents as ordered and failed to ensure appropriate use of oxygen. This affected two residents (#19, #15) of five residents reviewed for respiratory care. The census was 38.Findings include: 1.Record review revealed Resident #19 was admitted to the facility on [DATE] with diagnoses including end stage renal disease and atrial fibrillation. Review of a care plan dated 02/26/19 revealed Resident #19 had an alteration in oxygen exchange/perfusion related to chronic respiratory failure and chronic obstructive pulmonary disease. The goal was for lungs to be clear to auscultation and oxygen saturation above 90%, respirations to be unlabored, and show adequate oxygen perfusion. Interventions included but were not limited to evaluate shortness of breath for pain and discomfort when breathing and administer medications as ordered to relieve and provide oxygen per orders. Review of orders revealed an order dated 04/30/26 for Resident #19 to have humidified oxygen via nasal cannula at three liters per minute continuously and check oxygen saturation each shift. Observation on 05/05/26 at 7:52 A.M. revealed Resident #19 was resting in bed and had oxygen in place via nasal cannula at four liters per minute. Observation on 05/05/26 at 1:31 P.M. revealed Resident #19 was seated in her wheelchair with oxygen in place via nasal cannula at four liters per minute. Interview on 05/06/26 at 6:45 A.M. with Maintenance Director (MD) #112 confirmed Resident #19 had oxygen in place via nasal cannula but was set to four liters per minute. Interview of 05/06/26 at 6:54 A.M. with Certified Nursing Assistant (CNA) #145 confirmed Resident #19's oxygen was set to four liters per minute. Review of an undated policy titled Nasal Cannula revealed the knob of the oxygen concentrator should be adjusted to the flow rate prescribed by the provider. 2, Record review revealed Resident #15 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), hypertension, muscle weakness with difficulty walking, and type two diabetes. Review of Resident #15's order placed on 03/18/26 revealed the resident required oxygen continuously at three liters per minute for shortness of breath and COPD. Review of Resident #15's care plan dated 04/07/26 revealed the resident had an alteration in respiratory function and required oxygen at three liters per minute via nasal canula. Goals included their oxygen level will be kept at desired levels set per physician through review date. Interventions include administering oxygen as ordered, monitor oxygen saturation levels as ordered, and observe the resident for signs and symptoms of dyspnea such as labored respirations, low oxygen saturation, use of accessory muscles, cyanosis, changes in mental status, and tachypnea. Review of Resident #15's care plan dated 04/07/26 revealed the resident had an alteration in (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	respiratory function related to COPD, and respiratory failure. Goals include the resident will be free from respiratory distress through the review date, the resident will show adequate oxygen perfusion through the review date, and oxygen saturation will be above 90% through the review date. Interventions include providing oxygen to the resident as ordered. Review of Resident #15's minimum data set (MDS) assessment completed 04/26/26 revealed a brief interview for mental status score of 9 indicating the resident had moderate cognitive impairment. Section O for special treatments revealed the resident required continuous oxygen therapy. Review of Resident #15 progress note dated 05/04/26 at 12:02 P.M. revealed the resident walked themself to the dining room without oxygen. Observation on 05/04/26 at 11:53 A.M. revealed Resident #15 in the dining room walking with walker towards door stating she needed air and could not breathe with pale lips, labored breathing, and delayed responses. Resident #15 then sat in a chair outside of the dining room and stated she was going to pass out, and she needed a nurse now. The surveyor remained with the resident, while an additional surveyor alerted a facility CNA of the resident and their status, trouble breathing, and requesting a nurse immediately. At 11:57 A.M. Registered Nurse (RN) #117 arrived to the resident, Resident #15 stated she needed air and couldn't breathe. Prior to placing oxygen on the resident or obtaining vital signs RN #117 guided resident to walk back into the dining room despite resident stating she felt like she was going to pass out. At 11:58 A.M. RN #117 placed the resident on oxygen via nasal cannula and obtained vital signs revealing an oxygen saturation of 67%.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and interview, the facility failed to ensure residents with known trauma were provided trauma informed care. This affected two residents (#28 and #36) of four residents reviewed for behaviors. The facility census was 38. Findings include:1.Record review revealed Resident #36 was admitted to the facility on [DATE] with diagnoses including post-traumatic stress disorder (PTSD) and depression. Review of a care plan dated [DATE] revealed Resident #36 was at risk for impaired social interaction related to PTSD due to her sister passing away which causes her to be upset. The goals included being free of or have decrease in undesirable behaviors and interactions with others and will have no decreased/personally acceptable level of stress from past trauma. Interventions included but were not limited to encourage deep breathing exercises when she is in a stressful situation; encourage positive communication with others; encourage to participate in activities she enjoys; encourage to talk about feelings when she is upset; and provide positive reinforcements. There were no triggers listed in the plan of care. Review of a Psychosocial/Behavioral Health assessment dated [DATE] revealed Resident #36 had a diagnosis of PTSD. There was no additional information. Review of a minimum data set (MDS) assessment dated [DATE] revealed Resident #36's cognition remained intact, had no behaviors, and had a diagnosis of PTSD. Interview on [DATE] at 10:52 A.M. with Social Services (SS) #108 revealed she assesses residents with PTSD by asking them questions about how they feel. She stated there used to be an assessment but not anymore. SS #108 stated she has not completed a care plan in a while but would usually ask if there had been trauma throughout their life then all the information would go into the care plan. SS #108 confirmed Resident #36 had a diagnosis of PTSD but did not have a comprehensive assessment completed and the care plan in place did not identify triggers for the resident. Review of an undated policy titled Trauma Informed Care revealed the facility's goal is to provide services that are supportive of trauma-related experiences to avoid reoccurrence of traumatization. For many trauma survivors, transitioning into a nursing facility can result in triggering re-traumatization. The facility should provide care to residents with a past or current trauma related experience to include any resident who displays or is diagnosed with a mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or PTSD in an effort to minimize any trauma related triggers that may trigger them. The licensed nurse will assess the resident for potential trauma related to past or current experiences upon admission, quarterly and with significant change. Any identified triggers will be documented and care-planned appropriately. The licensed nurse will notify the physician and/or responsible party of the identified findings as needed. A care plan will be developed that addresses the identified triggers and what interventions should be attempted upon admission quarterly, and with significant change. The care plan may address psychiatry and psychology services as well as community groups as needed. The facility staff will provide trauma-informed care according to the established care plan and document accordingly. 2. Review of Resident #28's medical record revealed the resident was originally admitted to the (continued on next page)

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Muskingum Skilled Nursing & Rehabilitation	501 Pinecrest Drive Beverly, OH 45715

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility on [DATE] with diagnoses including personality disorder, depression, generalized anxiety, post-traumatic stress disorder (PTSD), personal history of suicidal behavior, poisoning by benzodiazepines, and sedative, hypnotic or anxiolytic dependence, in remission. Review of Resident #28's psychiatric note dated [DATE] revealed the resident had PTSD and was stable on Zoloft (anti-depressant) and Xanax (anti-anxiety). The resident had PTSD from watching a friend wreck and die on a motorcycle when she was younger and it plays back in her head. She had attempted suicide. There was no documented evidence of triggers or individualized intervention. Review of Resident #28's quarterly psychosocial/behavioral assessment dated [DATE] revealed the resident had PTSD. The assessment did not include triggers or individualized interventions. Review of Resident #28 risk for impaired social interaction related to history of trauma plan of care dated [DATE] revealed (triggers) the resident had a really good friend being killed, son not wanting anything to do with her, PTSD, and history of suicidal behavior. The intervention included to encourage positive communication with others, verbalizing feelings, medication per order, notify physician of decline, offer psych services, provide positive reinforcements, refer to counseling/psychiatry, social to provide education regarding outpatient community resources and support groups, set up as indicated. There was no evidence of triggers or individual interventions. Review of a comprehensive diagnostic assessment/biopsychosocial assessments completed by visiting Licensed Social Worker (LSW) #401 dated [DATE] and [DATE] revealed the resident had PTSD. Short term goals included the resident would apply acquired relaxation skills when recounting experiences of the traumatic events. The plan did not include the residents' triggers or individualized interventions. Review of Resident #28's physician note dated [DATE] revealed the resident's chief complaint was panic attacks. The resident was tapered off Xanax several months ago. Since that time, the panic attacks have definitely gotten worse. She describes a feeling of impending doom, broke, breathless, and tremors. New orders to increase Zoloft to 200 milligrams (mg) daily and Xanax 0.5 mg every eight hours as needed for anxiety related to PTSD. Interview on [DATE] at 9:17 A.M., with Resident #28 revealed she had PTSD related to a combination of life events. She had watched a friend wreck a motorcycle in front of her and died, a few months later her house burnt down with her pets inside and she lost everything and she had been in bad relationship. She had been having panic attacks and has not been sleeping well since she was taken off Xanax almost a year ago. She was seen by the in-house psychiatrist, but he yelled at her, so she fired him. The resident reported she was stable when she was on the Zoloft and Xanax. Interview on [DATE] at 11:04 A.M. and 1:47 P.M., with Social Service Designee (SSD) #108 confirmed (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #28 did not have a comprehensive PTSD assessment or comprehensive care plan for PTSD to include triggers or individualized interventions. The SSD reported she knew the resident prior to becoming a resident at the facility. The resident watched a close friend get killed on a motorcycle and another one got shot and killed five years later. She doesn't talk a lot about it and shuts down. She refused to see psychologist, and she would have to look to see if anyone had been following her psychological needs. The SSD didn't know what the resident triggers for the PTSD included. Interview on [DATE] at 2:33 P.M., with visiting behavioral health Licensed Social Worker (LSW) #401 and Qualified Mental Health Specialist (QMHS) #400 confirmed they were a new psychiatric company contracted with the facility to provide mental health service. LSW #401 confirmed comprehensive diagnostic assessment/biopsychosocial assessments completed on [DATE] and [DATE] didn't include Resident #28's triggers for PTSD or individualized interventions. Interview on [DATE] at 7:13 A.M., with the Director of Nursing (DON) and Registered Nurse (RN) #117 confirmed the resident had fired the psychologist in [DATE] and had not been seen by mental health provider again until 10/2025. The DON confirmed the previous physician had seen the resident on [DATE] (last year) and recommended restarting Xanax due to it was effective, however the order was not implemented and on [DATE] the Nurse Practitioner did not want to restart the Xanax due to the medication could decrease the resident respirations. The new physician re-evaluated the resident on [DATE] and restarted the Xanax.

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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 medical record review, interview, review of infection control log, and review of policies the facility failed to ensure residents were free from unnecessary medications. This affected one resident (#31) of five residents reviewed for urinary tract infections and one resident (#10) of six residents reviewed for unnecessary medications. Findings include: 1. Medical record review revealed Resident #31 was admitted to the facility on [DATE] with diagnoses including chronic systolic heart failure, acute kidney failure, chronic obstructive pulmonary disease, pneumonia, sepsis, retention of urine, paroxysmal atrial fibrillation, prostatic hyperplasia without lower UTI system, varicose veins, gastro-esophageal reflux disease, edema, obstructive an reflux uropathy, Barrettes esophagus with dysplasia, voice and resonance disorder, laryngeal spasm, foot pain, opioid dependence, ventral hernia, leg pain, hypertension, and anxiety. Review of Resident #31's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a urinary foley catheter. Review of Resident #31's urinalysis dated 04/29/26 revealed the urine was collected on 04/29/26 received on 04/30/26 and reported on 05/02/26. The urine culture showed 26-300,000 proteus mirabilis and was resistant to Ciprofloxacin. Review of Resident #31's medication administration record (MAR) dated 05/2026 revealed the resident had started on Ciprofloxacin (antibiotic) 500 milligrams (mg) one twice a day for five days for urinary tract infection (UTI) starting on 05/01/26 at nighttime and ending on 05/04/26 in the morning. The resident received six of the 10 ordered doses of Cipro 500 mg. Review of Resident #31's McGeer's Criteria of Infection Surveillance dated 05/01/26 and locked on 05/09/26 revealed the criteria was completed for a UTI without an indwelling catheter (resident had an indwelling catheter). The resident had new or marked increase of frequency and met criteria; however, the organism section was left blank which was one of the criteria that needed to be marked to ensure criteria was met for treatment. Review of the April 2026 and May 2026 infection control log revealed no evidence Resident #31 was on the log for UTI or treatment of UTI. Interview on 05/05/26 at 10:54 A.M., with Resident #31 revealed he was treated for a urinary tract infection with the incorrect antibiotic. Interview on 05/12/26 at 11:47 A.M., with Registered Nurse (RN)/Infection Preventionist (IP) #117 confirmed Resident #31 did not meet criteria for antibiotic treatment and had received an antibiotic without justification. The IP also confirmed she had completed the McGeer form inaccurately due to the resident had a urinary foley catheter and he did not have greater than 100,000 of an organisms. The RN/IP #117 confirmed the resident had Cipro listed as an allergy, however it was given to him, and he didn't have a reaction, so the resident requested the medication be continued. The urinalysis was originally ordered by the urologist due to the resident's urine was dark in color not frequency of urine. The IP reported the facility has a contract with a company the nurses were to contact after hours and weekends. The providers were from all over the state, and they don't like to make changes to other providers orders so on Monday she had reached out to the facility's Nurse Practitioner (NP) (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	due to the resident's infection was resistant to Cipro and he didn't meet criteria for treatment and the NP discontinued the Cipro and she removed the Cipro allergy from the resident's medication allergy list. Review of the facility's policy titled Antibiotic Stewardship dated 01/2020 revealed the purpose of the policy was to ensure antibiotics were used only when truly needed and utilizing the correct antibiotic for each infection. 2. Record review revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including end stage renal disease and hyperlipidemia. Review of a care plan dated 07/29/25 revealed Resident #8 received pain medication. The goals included to be free from any adverse reactions from pain medication through review date and pain will remain within an acceptable range through review date. Interventions included but were not limited to administer medications per physician orders, monitor for effectiveness and potential side effects, notify physician of changes; consult physician to review medication if resident has persistent side effects from medication; monitor for potential fall risks; monitor for signs and symptoms of altered mental status, anxiety, constipation, depression, dizziness, lack of appetite, nausea, vomiting, pruritis, respiratory distress, sedation, urinary retention, and notify physician of changes; monitor respiratory status after administration of pain medication as indicated; and review and assess whether pain medication is effective. Review of an order dated 03/19/25 revealed Resident #8 had an order for Tylenol oral tablet give 500 milligrams (mg) by mouth every four hours as needed for pain, level one through four, and do not exceed 3000 mg in 24 hours. Review of an order dated 02/08/26 revealed Resident #8 had an order for oxycodone (narcotic pain medication) oral tablet 5 mg give one tablet by mouth every eight hours as needed for post surgery, six tablets only in place. There were no pain parameters included in the instructions for administration. Review of physician orders dated 02/21/24 revealed Resident #8 had an order for oxycodone-acetaminophen 5-325 mg give one tablet by mouth every six hours as needed for pain. There were no pain parameters included in the instructions for administration. Interview on 05/07/26 at 2:21 P.M. with the Director of Nursing (DON) confirmed there were no parameters in place for the narcotic medications to guide staff of when to administer the pain medications thereby leading the resident to unnecessary pain medication administration.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of facility investigation, review of Medscape drug information, review of policies, job description reviews and interviews the facility failed to prevent a significant medication error. This affected one resident (Resident #41) of three residents reviewed for hospice services. The facility census was 38. Findings include: Medical record review revealed Resident #41 was admitted to the facility on [DATE] with diagnoses including encephalopathy, chronic obstructive pulmonary disease, diabetes mellitus, asthma, dementia, major depression, long QT syndrome (condition affecting repolarization (relaxing) of the heart after a heartbeat. It results in an increased risk of an irregular heartbeat which can result in fainting, drowning, seizures, or sudden death), insomnia, pain, peripheral vascular disease, occlusion and stenosis of carotid artery. The resident was a full code status, and allergies included Duloxetine, Morphine, and Betadine. Review of Resident #41's orders revealed Atenolol (beta-blocker) 100 milligrams (mg) in the morning for hypertension, oxybutynin 15 mg daily for urinary retention, Plavix (antiplatelet) 75 mg for heart disease, Zoloft 100 mg daily for depression, Gabapentin 600 mg twice daily for neuropathy, Lantus 100 units subcutaneously twice daily for diabetes, Metformin 1,000 mg twice daily for diabetes, Cephalexin 500 mg give two tablets three times a day for osteomyelitis, Combivent inhaler one puff four times a day for chronic obstructive pulmonary disease, check blood sugar before meals and at bedtime, and Tramadol 50 mg every six hours for pain. The resident also received Hospice services for hypertensive heart disease.Review of Resident #41's plan of care dated 02/11/25 revealed the resident had alteration in cardiac function related to hypertension, peripheral vascular disease, stenosis of carotid artery, and long QT syndrome. Interventions included administering medications per physician orders, monitoring adverse reactions to medication and reporting to medical doctor if noted, monitoring lung sounds and report abnormal finding to medical doctor as needed, and to monitor vitals and report abnormal findings to medical director. Review of Resident #41's admission minimum data set (MDS) dated [DATE] revealed. Resident #41 was admitted to the facility on [DATE] in bed B. The resident's brief interview for mental status (BIMS) was noted to be 13 (cognition intact). Review of the Medication Error Report Form dated 02/25/26, completed by the Director of Nursing (DON), revealed at 9:00 A.M., Resident #41 was administered the wrong medication. The Certified Medication Aide (CMA) #108 was passing medication, and two other (unidentified) residents came to the medication cart wanting their morning medications. The CMA told them she would be there soon. The CMA went into the room of Resident #41 (bed B) and #49 (bed A) and gave the medication to bed B (Resident #41) instead of bed A (Resident #49). The incident was reported to the physician, DON, and family. The report was signed by the DON and Administrator on 02/25/26. Review of electronic medication error report dated 02/25/26 at 9:00 A.M. and completed by the Assistant Director of Nursing (ADON)/Registered Nurse (RN) #117 revealed Resident #41 had received his roommate's medication with no adverse reactions noted at this time. Resident #41's head to toe assessments completed within normal limits. The provider was notified and all medications reviewed to make sure no allergies were detected. Residents were made aware of situation and every two hours vital sign times one, then every four-hours times 24 hours initiated. Resident in agreement with plan of care. The level of consciousness, mobility, and mental status were unanswered (not assessed per the medication error report). Resident #41 was notified on 02/25/26 at 11:49 A.M., the provider at 11:28 A.M., and the DON at 11:28 A.M. Review of the facility's investigation regarding Resident #41's medication error on 02/25/26 revealed the investigation included: a list of the resident blood pressure readings (printed 04/28/26), an undated handwritten list of medications (determined to be Resident #49's morning medications that were erroneously administered to Resident #41) (Thiamine 100 mg (Vitamin), Carvedilol (Beta-Blocker) Propranolol (antidysrhythmic/beta blocker), Lisinopril (ace-inhibitors), Ascorbic Acid (Vitamin), Aspirin, Amlodipine (calcium channel blocker), Pantoprazole (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(proton pump inhibitors), Venlafaxine (antidepressant), Folic Acid (vitamin), Buprenorphine (opioid analgesic that is also known as Suboxone), Baclofen (muscle relaxer), and sennoside (stool softener), staff education on five rights, interruptions during medication administration, and to watch for last names that look alike or sound alike dated 02/25/25, a written medication error report form dated 02/25/26, and an electronic medication error report dated 02/25/26. There was no evidence of a comprehensive assessment including vital signs, documentation of the incident in the medical record (progress note), a comprehensive list of medications the residents were prescribed including dosage, any new orders received because of the error.Review of Resident #41's medication administration records dated 02/25/26 revealed the resident's medication administration included: Atenolol (beta-blocker) 100 milligrams (mg) in the morning for hypertension which was held on 02/25/26, oxybutynin 15 mg daily for urinary retention, Plavix (antiplatelet) 75 mg for heart disease, Zoloft 100 mg daily for depression, Gabapentin 600 mg twice daily for neuropathy, which both doses were held on 02/25/26, Lantus 100 units subcutaneously twice daily for diabetes, Metformin 1,000 mg twice daily for diabetes, Cephalexin 500 mg give two tablets three times a day for osteomyelitis, Combivent inhaler one puff four times a day for chronic obstructive pulmonary disease, check blood sugar before meals and at bedtime was not completed at dinner due to the resident was sleeping, and Tramadol 50 mg every six hours for pain was not administered at noon and 6:00 P.M. due to the resident was sleeping. Review of Resident #49's (Resident #41 roommate) medication orders for February 2026 revealed Amlodipine 5 mg daily for hypertension, Ascorbic acid 500 mg daily for supplement, Aspirin 81 mg daily for anti-platelet, Baclofen 20 mg three times daily for muscle spasms, Buprenorphine 8 mg sublingual three times daily for detox, Carvedilol 6.25 mg twice daily for hypertension, Folic acid 1 mg daily for anemia, Lisinopril 40 mg daily for hypertension, Pantoprazole daily for gastric reflux disease, Propranolol 120 mg daily for hypertension, Thiamine 100 mg daily for supplement, Venlafaxine 50 mg daily for depression, and Sennosides 8.6 mg one twice daily. Resident #49's diagnoses included cirrhosis of the liver, anemia, emphysema, altered mental status, constipation, opioid dependence, metabolic and toxic encephalopathy, moderate protein-calorie malnutrition, paroxysmal atrial fibrillation, hypothyroidism, hypokalemia, and hypomagnesemia.Further review of Resident #41's medical record from 02/25/26 to 02/28/26 revealed no documentation of the medication error incident that occurred on 02/25/26. Additionally, there was no evidence of comprehensive nursing assessments related to the medication error or follow-up during the time frame. There were no medical practitioner orders to monitor the resident. Interview on 04/28/26 at 3:39 P.M. and follow up interview on 04/29/26 at 8:21 A.M. with the Director of Nursing (DON), confirmed CMA #108had administered Resident #49's medication to Resident #41 on 02/25/26. The DON reported she notified Nurse Practitioner (NP) #200 after the incident and received new orders to monitor the resident, obtain vital signs every two hours times one, then every four hours for 24 hours, and to hold sedative medication due to the resident would probably sleep all day after receiving Buprenorphine, however she never wrote the orders. The DON also confirmed the significant medication error, comprehensive assessment immediately following and as follow up after the incident were not documented in the medical record. Interview on 04/29/26 at 7:50 A.M., with CMA #108 confirmed she had administered Resident #49's medication to Resident #41 on 02/25/26. The CMA reported she had been interrupted during the medication administration pass twice by other residents. The CMA reported she thought Resident #41 was in bed A and then switched to bed B so he could be by the window and in her mind he was still in bed A, however Resident #49 was in bed A. As soon as Resident #41 swallowed the medication she knew what she did, but it was too late. CMA #108 said she went directly to the DON and reported the medication error. The CMA reported Resident #41 had slept the remainder of the day and until lunch time the following day. Interview on 04/29/26 at 9:00 A.M., with Assistant Director of Nursing (ADON)/ Registered Nurse (RN) #117 the ADON reported the resident had slept most of the day on the 25th and he didn't eat lunch on the 25th and she had left around 5:00 P.M. so she didn't know what he had for dinner. The following day the resident didn't arouse until around 1:00 P.M., but (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he wasn't himself. Interview on 04/29/26 at 9:41 A.M., with NP #200 confirmed she had just taken over as the NP for the facility around the time of medication error involving Resident #41. The NP confirmed she had spoken to the DON and had given verbal order to monitor the resident, which would include orientation, if he was lethargic, not eating, behaviors changes, etc. Review of www.medscape.com revealed Buprenorphine for opioid dependence 8 mg should be administered sublingual on day 1, then 16 mg on day 2, continued over 3-4 days. The black box warning included an accidental exposure of even one dose that can result in a fatal overdose. Accidental exposure reports included fatalities. Avoid with patients with history of long QT syndrome. Monitor for respiratory depression especially during the initiation. Serious, life-threating, or fatal respiratory depression reported; may occur more frequently in elderly. May impair mental and physical albitites. Risk of apnea in patients with chronic pulmonary disease, closely monitor these patients, when initiating and titrating therapy. Carvedilol and Propranolol may worsen bradycardia and cause hyperglycemia. Monitor heart rate. Review of the Certified Medication Aide (CMA) job description undated revealed the primary purpose of the CMA was to assist the licensed nurse (Registered Nurse (RN) or Licensed Practical Nurse (LPN) in providing safe and ethical care for clients-that is administering prescribed drugs and completing other delegated tasks allowed by state law. The CMA duties and responsibilities included to dispense oral medication to residents under direct supervision of a licensed nurse unless otherwise allowed by state law. Observe residents for drug reactions and report any problems to the licensed nurse. Perform task safely and effectively to assure resident comfort and welfare. Report to the nurse any deviation from the delegated medication administration, any unanticipated resident reaction to the medication administration, or anything that causes concern about the condition of the resident. Review of the facility policy and procedure titled Medication Error Reporting and Adverse Drug Reaction Prevention and Detection dated 01/2023 revealed medication errors and adverse drug reactions are assessed, documented, and reported as appropriate to the resident's attending physician and/or prescribers, the Pharmaceutical Service Committee, the pharmacy, and Food and Drug Administration MedWatch Program or USP/ISMP Medication Error Reporting Program. The facility staff monitor the resident for possible medication related adverse consequences, including mental status and level of consciousness, evaluation of the resident's side effects of medication, including sedation, lethargy, agitation, mental status changes, and behavior changes that affect the residents ability to perform activities of daily living or interact with others or cause diminished ability to think or concentrate. In the event of a significant medication error or adverse drug reaction, immediate action is taken, as necessary, to prevent the residents' safety and welfare. The prescriber is notified promptly of any significant error or adverse medication reactions. Any new prescriber's orders are implemented, and the resident is monitored closely for 24 to 72 hours or as directed. The incident is described on the shift change report to alert staff of the need to monitor the resident. The following information is documented in the resident's medical record and/or on the incident report: factual description of the error or adverse reaction, name of the prescriber and time notified, prescriber's subsequent orders, and residents' condition for 24 to 72 hours or as directed.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview, review of hospice contracts and hospice documentation review the facility failed to ensure hospice plans and visits were maintained at the facility and failed to ensure the facility contactwas identified for hospice service contact. This affected three residents (Resident #41, #47 and #48) of four residents reviewed for hospice services. The facility census was 38. Findings include: 1. Medical record review revealed Resident #41 was admitted to the facility on [DATE] with diagnoses including encephalopathy, osteomyelitis, chronic obstructive pulmonary disease, diabetes mellitus, asthma, dementia, major depression, urge incontinence, anxiety, long QT syndrome, insomnia, pain, peripheral vascular disease, Vitamin D Deficiency restless leg syndrome, gastritis, constipation, occlusion and stenosis of carotid artery, hyperglycemia, hyperlipidemia, nocturia, and hypomagnesemia. Review of Resident #41's hospice contract dated [DATE] revealed the facility shall ensure hospice patients are kept comfortable, clean, well-groomed and protected from negligent and intentional harm including, but not limited to accidents, injury, or infection. Hospice and the facility shall communicate with one another regularly and as needed, via phone, fax, email, and/or in person. Each party is responsible for documenting such communications in tis respective clinical records to ensure that the needs of the hospice patient are met 24hours a day. The facility shall immediately inform hospice of any change in the condition of a hospice patient. Each party shall prepare and maintain complete and detailed records. Each party shall maintain records for a minimum of six years from the date of discharge. The records shall include evaluations, treatments, progress notes, authorizations to admission, physician orders, and discharge summaries.Review of Resident #41's hospice plan of care dated [DATE] revealed to contact hospice for change in resident condition, administer medications as ordered, and hospice to collaborate care with facility staff.Review of Resident #41's electronic medical record and hospice binder revealed no evidence of hospice notes or hospice plan of care. Interview on [DATE] at 10:32 A.M., with the Director of Nursing (DON) confirmed the hospice staff usually talk with her or floor staff when they enter the building, however they don't always follow up with staff prior to leaving. If there was a new order hospice usually would email her the new order. The facility currently has three hospice companies providing service to the residents. Interview on [DATE] at 9:53 A.M., and [DATE] at 8:30 A.M., with the Director of Nursing (DON) confirmed the facility had to call hospice to obtain hospice notes and plan of care. The hospice binders are usually kept at the nurse's station however, the resident requested the binder to be kept in his room and now it cannot be located, and the facility did not keep copies for their records. Observation on [DATE] at 8:30 A.M., of Resident #41's room with the DON revealed no evidence the hospice binder was located in the resident's room or at the nurse's station. There was no evidence in the medical record or contract of who the facility's contact designee was. 2. Closed medical record review revealed Resident #47 was admitted to the facility on [DATE] with diagnoses including protein calorie malnutrition, senile degeneration of the brain, hemiplegia, diabetes, mental disorder, dementia, anxiety and depression and expired on [DATE]. Review of Resident #47's orders dated 02/2026 revealed the resident was admitted under hospice services on [DATE] for senile degeneration. Review of Resident #47 electronic medical record and paper medical record revealed no evidence hospice certification, hospice's plan of care, or progress notes from hospice. Review of the facility's hospice contract dated [DATE] revealed the facility staff would provide services under the care plan established by the Hospice team. The care plan will be maintained by the facility and hospice. The facility and hospice will prepare and maintain an integrated medical record for reach resident who had elected hospice care. The medical record established and maintained by the facility will contain all documents related to the management services call for in the hospice plan of care and will include a record of hospice personnel involvement in the care of the residents. There was no (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evidence in the medical record or contract of who the facility's contact designee was. Interview on [DATE] at 9:53 A.M., with the Director of Nursing (DON) confirmed the facility didn't have Resident #47 hospice certification, hospice plan of care, or hospice progress notes and she had to call hospice to obtain records. 3. Closed medical review revealed Resident #48 was admitted to the facility on [DATE] with diagnoses including dementia, scoliosis, ulcerated proctitis, depression, anemia, anxiety, and gastro-esophageal reflux and expired on [DATE]. Review of Resident #48's hospice plan of care initiated [DATE] and cancelled on [DATE] revealed hospice to collaborate care with facility staff. Review of Resident #48's quarterly MDS dated [DATE] revealed the resident was receiving hospice services. Review of Resident #48's electronic and paper medical record revealed no evidence of hospice certification, plan of care, or progress notes. Review of the facility's hospice contract dated [DATE] revealed the facility staff would provide services under the care plan established by the Hospice team. The care plan will be maintained by the facility and hospice. The facility and hospice will prepare and maintain an integrated medical record for reach resident who had elected hospice care. The medical record established and maintained by the facility will contain all documents related to the management services call for in the hospice plan of care and will include a record of hospice personnel involvement in the care of the residents. There was no evidence in the medical record or contract of who the facility's contact designee was. Interview on [DATE] at 8:08 A.M., with DON confirmed the paper or electronic medical record contained the resident hospice certification, hospice plan of care, or hospice progress notes. The DON reported she thought maybe Medical Records #114 was the facility's hospice designee. Interview on [DATE] at 8:28 A.M., with Medical Records #114 confirmed she was not the hospice contact designee and maybe it was the social service designee. Interview on [DATE] at 9:00 A.M., with Social Service Designee (SSD) confirmed she was not the hospice contact designee. Interview on [DATE] at 2:48 P.M., with the DON revealed moving forward she would be the facility's contact designee for hospice.