STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365466	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Heath	717 South 30th Street Heath, OH 43056

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interview, and staff interview, the facility failed to allow a resident to choose to eat a diet texture of their preference when the resident's diet was downgraded without appropriate tests or evaluations completed. This affected one (#49) of one residents reviewed for choices. The census was 112. Findings Include:Review of the medical record revealed Resident #49 was admitted to the facility on [DATE]. His diagnoses included amyotrophic lateral sclerosis (ALS), congestive heart failure, hypertensive heart failure, type II diabetes, hyperlipidemia, dysphagia, ischemic cardiomyopathy, atherosclerotic heart disease, old myocardial infarction, nicotine dependence, and non-compliance with other medical treatment and regimen. Review of Resident #49's Minimum Data Set (MDS) assessment, dated 07/02/25, revealed he was cognitively intact. Review of Resident #49's After Visit Summary Hospital form, dated 01/04/24, revealed he was admitted to the hospital for teeth extraction and to treat a tooth/mouth infection. He was admitted back to the facility on [DATE]. Further review revealed a recommendation was made from the hospital for Resident #49 to utilize a soft diet of, **** days after the procedure, but the specific number of days were not identified. There was no documentation that the hospital recommended a long-term diet texture downgrade or a downgrade of his nutritional status.Review of Resident #49's progress note, dated 01/09/24, revealed the resident was referred to speech therapy services. The note revealed nursing reported the resident was coughing on thin liquids and eliciting difficulty with whole medications. Speech Language Pathologist (SLP) #102 spoke with the resident who became agitated when given recommendations and education on diet recommendations/swallow strategies. Resident #49 was educated on reducing aspiration with thickened liquids/crushed medications and the resident reported he only coughed because he was sick and wants staff to leave him be. SLP #102 educated the resident that he was at risk for aspiration, pneumonia, and death if diet recommendations and swallow strategies were not followed and the resident continued to aspirate. Resident #49 returned understanding of the information. Resident #49 also recently had teeth pulled and the resident's swallow function continued to decline due to ALS. Resident #49 was educated on prognosis regarding swallowing, given SLP's name, and encouraged to participate. Resident #49 nodded his head acknowledging the clinician.Review of Resident #49's SLP Discharge Summary document, dated 05/20/24, revealed Resident #49's therapy was to be primarily focused on education. Resident #49 asked to complete a modified barium swallow study (MBSS) to establish a baseline. There was no documentation presented in the document that Resident #49 had a MBSS completed to support the downgrade of his diet.Review of Resident #49's current dietary orders revealed the facility ordered the resident to be downgraded to a pureed texture diet. There was no documentation provided to support medical tests or assessments that were completed to warrant the downgrade.Review of Resident #49's clinical progress notes, dated 02/09/24, 02/28/24, 03/27/24, 05/29/24, 08/14/24, 12/27/24, and 05/13/25, confirmed Resident #49 expression of displeasure for having a pureed texture diet order. There was no documentation to support the facility giving him the option to revert back to a regular texture diet order with the understanding the resident understood the risks associated with it.Interview with Resident #49 (through electronic means) on 09/08/25 at 2:00 P.M. and 09/15/25 at 1:23 P.M. confirmed he refused meals in the facility because he did not want to eat pureed texture food. He confirmed the facility had not offered him any other choices or abilities to eat food provided by the facility, unless it was pureed. He confirmed he had to purchase his own food since January 2024, because the facility will not provide food other than food that was pureed.Interview with Dietitian #101 on 09/11/25 at 9:15 A.M. confirmed Resident #49 had a pureed texture diet order. She confirmed the facility did not offer him any food that was not pureed texture.Interview with SLP #102 on 09/15/25 at 2:52 P.M. confirmed he was not able to change Resident #49's diet order back to mechanical soft or regular texture until he had another swallow study done. SLP #102 confirmed the facility was to provide a pureed texture diet.Interview with Licensed Practical Nurse (LPN) #214 on 09/15/25 at 3:24 P.M. confirmed Resident #49 had a pureed texture diet order. She confirmed the facility does not offer Resident #49 food that would not be pureed.This deficiency represents non-compliance investigated with Complaint Number 2586509.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, staff interview, review of cleaning schedules, and facility policy review, the facility failed to maintain an clean and homelike environment. This deficient practice affected four (#3, #60, #93, and #105) of 112 residents observed for homelike environment. The facility census was 112.Findings Include:An observation on 09/08/25 at 10:30 A.M. revealed Resident #3 lying in bed with the bed covers pulled up to cover lower body. There were several dark brown stains noted on the white window blinds which were in the half-open position.An observation on 09/08/25 at 2:21 P.M. revealed Resident #93's room had cobwebs located in the corners where the wall met the ceiling and in the windowsill. The floor was dirty with noted stains along the baseboard under the heating and cooling unit and under the three-drawer dresser beside the bed. Further observation revealed Resident #93's fitted and flat sheets were noted to be soiled with dark brown stains near the edge of the bed.An observation on 09/08/25 at 2:30 P.M. revealed Resident #105 sitting in his wheelchair completing a puzzle on the empty bed in his room. The wall directly behind the empty bed was noted to be deeply scratched with several areas of exposed dry wall material noted. The scratches appeared to be approximately one-half inch deep and covered the majority of the lower part of the wall.An observation on 09/10/25 at 8:15 A.M. revealed Resident #60's room with the over the bed light fixture, for bed A, to be uncovered exposing the two florescent light bulbs, the light was turned on. There was no bed located under the light fixture. Resident #60's bed was located closest to the window.A review of the housekeeping room cleaning schedules dated 09/08/25 and 09/09/25 revealed Resident #3 and Resident #93's rooms had been marked as being cleaned by the housekeeping staff.An interview on 09/15/25 at 11:52 A.M. with Maintenance Director (MD) #531 confirmed the unclean conditions in Resident #3 and Resident #93's rooms, the exposed dry wall material in Resident #105's room, and the exposed light bulbs in Resident #60's room.Review of the facility's housekeeping services policy, dated 07/08/25, revealed the purpose was to promote a sanitary environment. This deficiency represents non-compliance investigated under Master Complaint Number 2614276 and Complaint Number 2573417.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on medical record review, staff interview, and facility policy review, the facility failed to ensure residents had an appropriate diagnosis for use of an antipsychotic medication and failed to provide proper justification for not attempting a gradual dose reduction for a resident's psychotropic medication. This affected two (#118 and #4) of six residents reviewed for psychotropic medications. The facility census was 112.Findings include:1. Review of the medical record for Resident #118 revealed an admission date of 09/03/25 with diagnoses including acute and chronic respiratory failure with hypercapnia, interstitial pulmonary disease, type II diabetes mellitus with hyperglycemia, and acute kidney failure.Review of the physician orders for Resident #118 revealed an order dated 09/03/25 for olanzapine (antipsychotic medication) oral tablet five (5) milligram (mg) to be given one time a day at bedtime for anxiety.Interview on 09/10/25 at 2:13 P.M. with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) #311 confirmed Resident #118's diagnosis for olanzapine was not appropriate. Both staff members stated the resident came from the hospital with the medication, and there was no documented diagnosis and they could not give him a diagnosis. The staff members stated the physician reviews the medications upon admission and saw the residents in-house to do a complete assessment. The DON confirmed there was no psychiatric diagnosis Resident #118 had for olanzapine medication.Review of the facility policy titled, Psychotropic Medication Management, effective 09/10/25, revealed residents receiving psychoactive upon admission, those with new psychoactive medication orders will have an informed consent completed. The resident/family must be informed of risks/benefits and black box warnings. Per facility policy if residents are admitted with a psychotropic medication, without a clearly documented indication, the prescribing practitioner and the interdisciplinary team (IDT) should determine if continuing the medication is justified. 2. Review of the medical record for Resident #4 revealed an admission date of 02/06/24. Diagnoses included chronic obstructive pulmonary disease, diabetes mellitus, depression, bipolar disorder and anxiety disorder.Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/26/25, revealed the Resident #4 had intact cognition. Review of the plan of care dated 02/26/24 revealed Resident #4 was at risk for side effects of medication due to antidepressants, antianxiety, and antipsychotic medication therapy. Interventions included to assess pain and offer treatment as indicated and offer nonpharmacological interventions.Review of physician orders as of 09/15/25 revealed Resident #4 was ordered the antihistamine with sedative and anxiolytic effects hydroxyzine oral tablet 50 milligrams (mg) three times per day for anxiety; the antidepressant trazodone oral Tablet 50 mg for insomnia, and the antianxiety medication buspirone oral tablet 15 mg four times per day for anxiety.Review of pharmacy recommendations dated 11/08/24 for Resident #4 revealed a gradual dose reduction request for hydroxyzine from 50 mg to 25 mg. Review of the physician response dated 11/14/24 revealed the provider denied the request because Resident #4 had scheduled surgery and he was having trouble sleeping.Review of pharmacy recommendations dated 12/09/24 for Resident #4 revealed a gradual dose reduction request for hydroxyzine 50 mg to 25 mg. Review of the physician response revealed the provider denied the request because Resident #4 had shoulder pain. During an interview on 09/11/25 at 9:29 A.M. with Certified Nurse Practitioner #301 stated she had not received a request from the pharmacy team to decrease Resident #4's dose of hydroxyzine since December 2024.Review of the facility policy titled, Psychotropic Medication Management, dated 09/10/25, revealed a gradual dose reduction must be attempted in two separate quarters unless clinically contraindicated.

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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 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 medical record review, observation, and staff interview, the facility failed to provide assistance with personal hygiene for a resident who was dependent for care. This deficient practice affected one (#63) of eight residents reviewed for activities of daily living. The census was 112.Findings Include:Review of the medical record for Resident #63 revealed an admission date of 07/11/23 with diagnoses including but not limited to heart disease, depression, seizures, and intellectual disabilities. Review of Resident #63 quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #63 had impaired cognition with a Brief Interview of Mental Status (BIMS) score of seven out possible 15, and required moderate to dependent assistance from staff to complete activities of daily living (ADLs) tasks including personal hygiene and shaving of facial hair.Review of Resident #63's functional ability deficit care plan dated 06/06/24 revealed assistance from staff was required to complete personal hygiene tasks.An observation on 09/08/25 at 10:14 A.M. revealed Resident #63 resting in bed and watching television. Resident #63 had noticeable facial hair on her upper lip and chin area.An observation on 09/09/25 at 8:43 A.M. revealed Resident #63 consuming the breakfast meal. Resident #63 continued to have noticeable facial hair on her upper lip and chin.An interview on 09/09/25 at 3:20 P.M. with Unit Manager (UM) #373 confirmed Resident #63 had noticeable facial hair on upper lip and chin. UM #373 stated the staff should be offering to shave Resident #63 during her shower and as needed when facial hair was noticeable to others. UM #373 further stated Resident #63 does go to activities and will be out in the unit lounge, where she would be seen by peer residents and facility visitors.This deficiency represents non-compliance investigated under Complaint Number 2586509.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, review of census information, resident interview, and staff interview, the facility failed to provide meaningful activities per resident preference. This affected one (#86) of four residents reviewed for activities. The census was 112.Findings include:Review of Resident #86's medical record revealed an admission date of 02/23/10 with diagnosis including Parkinson's disease with dyskinesia, bipolar disorder, obsessive-compulsive disorder, unspecified psychosis not due to a substance or known physiological condition, suicidal ideations, schizophrenia, and visual and auditory hallucinations. Review of Resident #86 annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident with intact cognition.Review of an activity plan of care created 02/25/20, and revised 09/09/23, revealed Resident #86 preferred to engage in activities independently. He preferred to stay in his room and sleep. He wears a headset to keep out noise, and will walk in the halls in the afternoon and evening.Review of an activities evaluation dated 06/13/25 revealed Resident #86 preferred to do activities independently in his room. He likes to watch television (TV) and movies, spend time outside when the weather was nice, listen to music, and take naps. The resident preferred activities in his room in the afternoon and evenings and one-on-one activity. Further review of Resident #86's activity documentation for the activity of watching TV/movies revealed no evidence of the activity being completed for thirty days.Interview on 09/09/25 at 8:35 A.M. with Resident #86 revealed he had a TV but it came off the wall and they have not put it back up. Observation throughout the survey revealed Resident #86 did not have a TV in his room. Interview on 09/11/25 at 11:20 A.M. with Activities Director (AD) #325 stated the activity staff talk to Resident #86 and tell him what was going on that day in activities. AD #325 stated Resident #86 preferred to stay in his room, liked to be by himself, and he does not want people in his room. AD #325 stated staff have taken things to Resident #86 for him to do, and he throws them back at them. AD #325 confirmed Resident #86 had moved rooms several times and did not have a TV in his new room. Review of Resident #86's census details revealed his last room move was in April 2025.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and facility policy review, the facility failed to implement splint/brace program for a resident with bilateral hand contractures. This deficient practice affected one (#47) of two residents reviewed for positioning and mobility. The facility census was 112.Findings Include:Review of the medical record for Resident #47 revealed an initial admission date 02/08/23 and a re-admission date 03/14/23. Diagnoses included but were not limited to bipolar disorder, anxiety, depression, suicidal behavior, and contractures.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #47 had impaired cognition with a Brief Interview of Mental Status (BIMS) score of two out of possible 15. Resident #47 was dependent on staff for care, bathing, and transfers. Resident #47 was able to feed self, but preferred staff to assist with eating.Review of Resident #47's nutritional care plan dated 02/09/23 revealed Resident #47 was at risk for malnutrition related to refusals of meals and assistance with eating. Further review revealed a skin care plan dated 02/08/23 indicating Resident #47 was at risk for impaired skin related to contractures, incontinence, and dependent on wheelchair for mobility.Review of Resident #47's occupational therapy (OT) Discharge summary dated [DATE] revealed Resident #47's tolerated wearing bilateral hand splints for up to two hours. Further review revealed OT recommendations for floor staff to complete passive range of motion (PROM) exercises to the left hand, active range of motion (AROM) exercises to the right hand, splint use, and verbal ques with self-feeding.Review of Resident #47's physician orders dated 09/01/25 to 09/30/25 revealed there were no orders for the use of braces/splints for bilateral hand contractures or any type of restorative program for PROM and AROM exercises to be completed.An observation on 09/08/25 at 3:44 P.M. revealed Resident #47 sleeping in bed lying on her left side. Resident #47's bilateral hands were visible, with the left hand and fingers curled into the palm of the hand and the right hand and fingers flat with the fingers hyperextended upwards. There were no splints visible in the room.An interview on 09/15/25 at 10:17 A.M. with Therapy Director (TD) #550 revealed Resident #47 was discharged from OT services on 01/13/25. OT staff completed education with restorative staff on splint use and PROM/AROM exercises for Resident #47. OT did not write the orders or complete the evaluation for the implementation of a splint and ROM restorative program for Resident #47. TD #550 stated Resident #47 did have custom bilateral hand splints in her room and they had been used during OT services. An interview on 09/15/25 at 10:25 A.M. with Assistant Director of Nursing (ADON) #311 confirmed Resident #47 did not have a restorative program implemented for PROM and AROM exercises and for bilateral use of hand splints. ADON #311 stated there had not been an evaluation completed or a restorative program order written by the OT for the nursing restorative staff to complete and/or follow.Review of the facility's brace and splint Program policy, dated 04/05/24, revealed properly used splints and braces can enhance mobility, correct alignment and protect specific extremity while maintaining skin integrity and circulation, and avoiding other possible adverse effects of the device. The purpose of the brace and splint program is to achieve the highest level of independence possible.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review, review of fall investigations, staff interview, and facility policy review, the facility failed to implement appropriate interventions and properly address repeated non-compliance with interventions to prevent resident falls. This deficient practice affected one (#14) of four residents reviewed for falls and accidents. The facility census was 112.Findings Include:Review of the medical record for the Resident #14 revealed an admission date of 06/12/06. Diagnoses included dementia, diabetes, anxiety disorder, and glaucoma.Review of Resident #14's quarterly Minimum Data Set (MDS) assessment, dated 07/17/25, revealed the resident had impaired cognition. Review of the plan of care dated 07/31/25 revealed Resident #14 was at risk for fall related injury and falls due to a history of falls and his requirements for assistance with activities of daily living (ADLs). Interventions included to keep the resident's call light within reach so he can call for assistance with transferring and to wear non-skid footwear when he was not in bed. Review of the plan of care dated 07/31/25 also revealed Resident #14 chose not to follow fall interventions. Interventions included praising Resident #14 when his behavior was appropriate.Review of the nurses notes from 01/01/25 to 09/15/25 revealed Resident #14 had unwitnessed falls on 01/27/25, 02/10/25, 03/16/25, 04/22/25, 05/03/25, 05/28/25, 06/16/25, 07/01/25, 07/16/25, 07/08/25, 07/30/25, 08/30/25, and 09/08/25. Review of the fall investigations dated 01/28/25, 05/05/25, 05/28/25, and 07/07/25 completed by the interdisciplinary team (IDT) revealed Resident #14 slipped on his bedroom floor because the resident was not wearing non-skid footwear. He was educated to wear non-skid footwear anytime he was out of bed. Review of the fall investigations dated 07/31/25 and 09/02/25 by the IDT revealed Resident #14 slipped while transferring, but the fall investigation did not mention if the resident was wearing non-slip footwear.During an interview on 09/11/25 at 11:15 A.M. with Unit Manager (UM) #204 confirmed Resident #14 had been educated numerous times about wearing non-slip footwear when out of bed, but he was non-compliant. She was not able to provide any interventions for his non-compliance.During an interview on 09/11/25 at 2:14 P. M. with the Director of Nursing (DON) confirmed Resident #14 was non-compliant with his fall interventions. She also acknowledged he had 36 falls in the past two years and confirmed all of the falls occurred since they determined he was non-compliant with the interventions. The DON also acknowledge the interventions were repetitive and not working. She stated the facility will attempt to move the resident's room closer to the nursing station for additional monitoring and will institute more frequent checks on Resident #14 from staff. Review of a facility policy titled, Fall Management, dated 07/08/25, revealed the facility will review all resident falls within 24 to 72 hours at the stand-up/clinic-ops meeting to evaluate/investigate the circumstances and probable cause for the fall, review/modify the plan of care to minimize repeat falls.

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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. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interview, staff interview, and facility policy review, the facility failed to properly assess a resident prior to making a diet order change, and failed to properly, accurately, and timely obtain resident weights and notify the physician of weight changes as ordered. This affected three (#49, #2, and #9) of eight residents reviewed for nutrition. The census was 112. Findings Include:1. Review of the medical record revealed Resident #49 was admitted to the facility on [DATE]. His diagnoses included amyotrophic lateral sclerosis (ALS), congestive heart failure, hypertensive heart failure, type II diabetes, hyperlipidemia, dysphagia, ischemic cardiomyopathy, atherosclerotic heart disease, old myocardial infarction, nicotine dependence, and non-compliance with other medical treatment and regimen. Review of Resident #49's Minimum Data Set (MDS) assessment, dated 07/02/25, revealed he was cognitively intact. Review of Resident #49's After Visit Summary Hospital form, dated 01/04/24, revealed he was admitted to the hospital for teeth extraction and to treat a tooth/mouth infection. He was admitted back to the facility on [DATE]. Further review revealed a recommendation was made from the hospital for Resident #49 to utilize a soft diet of, **** days after the procedure, but the specific number of days were not identified. There was no documentation that the hospital recommended a long-term diet texture downgrade or a downgrade of his nutritional status. Review of Resident #49's progress note, dated 01/09/24, revealed the resident was referred to speech therapy services. The note revealed nursing reported the resident was coughing on thin liquids and eliciting difficulty with whole medications. Speech Language Pathologist (SLP) #102 spoke with the resident who became agitated when given recommendations and education on diet recommendations/swallow strategies. Resident #49 was educated on reducing aspiration with thickened liquids/crushed medications and the resident reported he only coughed because he was sick and wants staff to leave him be. SLP #102 educated the resident that he was at risk for aspiration, pneumonia, and death if diet recommendations and swallow strategies were not followed and the resident continued to aspirate. Resident #49 returned understanding of the information. Resident #49 also recently had teeth pulled and the resident's swallow function continued to decline due to ALS. Resident #49 was educated on prognosis regarding swallowing, given SLP's name, and encouraged to participate. Resident #49 nodded his head acknowledging the clinician Review of Resident #49's nutritional orders, dated 01/22/24, revealed on that date, the facility changed his diet texture order from regular texture to pureed texture. Review of Resident #49 progress notes, dated 02/09/24, 02/28/24, 03/27/24, 05/29/24, 08/14/24, 12/27/24, and 05/13/25, revealed documentation to support Resident #49 was refusing meals at the facility due to the facility only offering meals with a pureed texture diet. There was no documentation to support a risk agreement/consent form was offered to Resident #49 to accept acknowledgement and responsibility for defying SLP recommendation/order for a pureed texture diet, which was not the diet texture he wanted. Review of Resident #49's SLP Discharge Summary document, dated 05/20/24, revealed Resident #49's therapy was to be primarily focused on education. Resident #49 asked to complete a modified barium swallow study (MBSS) to establish a baseline. There was no documentation presented in the document that Resident #49 had a MBSS completed to support the downgrade of his diet. Review of Resident #49 nutritional assessments, dated 07/08/24 and 07/03/25, revealed the resident was educated on risks of aspiration but continued to be non-compliant with diet texture. There was no documentation to support a medical assessment had been completed to confirm the resident medically needed to change his diet texture to puree. Review of Resident #49's medication administration records (MAR), dated July 2025 to September 2025, revealed multiple days in which Resident #49 refused his medications. But, when he did take his medications, they were whole pills with no modifications, including oxycodone, Baclofen, Lasix, and Senna. There were no orders for his medication to be crushed and there was no documentation to support the facility crushed his medications prior to giving them to him. Interview with Resident #49 on 09/08/25 at 2:00 P.M. and 09/15/25 at 1:23 P.M. confirmed he does not want to eat a pureed texture diet. He confirmed he had never received a swallow study or medical assessment to determine if he needed a pureed texture diet. He confirmed he has refused to have one because he has not shown signs that he needs to have an assessment completed or that he was having trouble swallowing. He orders his own food to be delivered and eats it with no issues. He confirmed he had never been given the opportunity to sign a risk agreement, understanding that he knows the risks of eating a regular texture diet. He stated the facility only offered food

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interview, and review of manufacturer guidelines, the facility failed to label Tuberculin (TB) solution (Tubersol) multi-use vials with a date when opened for use. This deficient practice had the potential to affect all 112 residents residing in the facility. The facility census was 112.Findings Include:1. An observation on 09/11/25 at 7:45 A.M. in the medication refrigerator in the Unit Three medication storage room revealed an opened multi-use vial of Tuberculin solution. There was no date on the vial or on the packaging box to reflect when the vial had been opened for use. The vial expiration was 04/2026.An interview on 09/11/25 at 7:47 A.M. with Medication Technician (MT) #339 confirmed the opened vial of Tuberculin solution without a date reflecting when the vial was opened for use. MT #339 stated the vial should be removed from use and discarded.2. An observation on 09/11/25 at 7:55 A.M. in the refrigerator in the Unit Two medication storage room revealed an opened multi-use vial of Tuberculin solution. There was no date on the vial or on the packaging box to reflect when the vial had been opened for use. The vial expiration date was 04/2026.An interview on 09/11/25 at 7:57 A.M. with Unit Manager (UM) #214 confirmed the opened vial of Tuberculin solution did not have a date of when the vial had been opened for use. UM #214 removed the vial from use and discarded it. UM #214 stated all new admissions receive a two-step TB test upon admission to the facility.3. An observation on 09/11/25 at 8:02 A.M. in the refrigerator in Unit One medication storage room revealed an opened multi-use vial of Tuberculin solution. There was no date on the vial or on the packaging box. The vial expiration date was 04/2026.An interview on 09/11/25 at 8:05 A.M. with UM #422 confirmed the opened vial of Tuberculin solution with no date reflecting when the vial had been opened for use. UM #422 removed the vial from use and discarded it.Review of the manufacturer guidelines for Tuberculin solution (Tubersol) dated 10/2021 revealed a vial of Tubersol which has been entered and in use for 30 days should be discarded.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interview, and staff interview, the facility failed to provide/offer timely dental services to residents as needed. This affected two (#49 and #6) of four residents reviewed for dental services. The census was 112. Findings Include:1. Review of the medical record revealed Resident #49 was admitted to the facility on [DATE]. His diagnoses included amyotrophic lateral sclerosis (ALS), congestive heart failure, hypertensive heart failure, type II diabetes, hyperlipidemia, dysphagia, ischemic cardiomyopathy, atherosclerotic heart disease, old myocardial infarction, nicotine dependence, and non-compliance with other medical treatment and regimen. Review of Resident #49's Minimum Data Set (MDS) assessment, dated 07/02/25, revealed he was cognitively intact.Review of Resident #49's dental progress notes, dated 01/19/24, confirmed Resident #24 was edentulous from a medical procedure that occurred earlier in the month at the hospital. The note also revealed they would complete impressions for dentures on the next visit. Review of Resident #49's progress notes, dated 11/14/24, revealed the facility received a new order to cancel the resident's dental appointment due to an insurance issue. Resident #49 was made aware and did not wish to have anyone else updated. Review of Resident #49's progress notes, dated 01/19/24 to 09/11/25, revealed no other dental appointments were attempted to be discussed or scheduled. Review of Resident #49's current care plan revealed a focus area related to being at risk for infection, pain, chewing issues, and bleeding in the oral cavity. Resident #49 had all of his natural teeth removed and had no dentures. Interventions for this care plan included to coordinate arrangements for dental care, dental consultation as needed, dental follow up as ordered, and observe/document/report to the physician as needed related to signs/symptoms of oral/dental problems needing attention. Interview with Resident #49 on 09/08/25 at 2:00 P.M. and 09/15/25 at 1:23 P.M. confirmed he did not have dentures. He confirmed it made it a little more challenging to eat his food, but he still can do it. He confirmed he wanted dentures, and the facility had not talked to him and/or attempted to schedule a dental appointment for his dentures. Interview with Assistant Director of Nursing (ADON) #311 on 09/15/25 at 2:16 P.M. confirmed the only dental note the facility had about an appointment for Resident #49's dental needs was the one provided from 11/14/24. ADON #311 confirmed they have no other evidence to support that denture impressions and/or dental appointments were discussed with Resident #49.2. Record review for Resident #6 revealed the resident was admitted to the facility on [DATE] with diagnoses including dementia, hypertension, and anxiety. Review of the quarterly MDS assessment dated [DATE] revealed Resident #6 had impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) score of six. The resident was assessed to require assistance with self-care activities.Review of the care plan dated 08/19/25 revealed Resident #6 was at risk for infection, pain, and chewing issues due to her being dependent on the facility staff for oral care. Interventions included staff observation of the resident for oral/dental issues and for staff to make dental appointments as needed.During an interview with Resident #6 on 09/08/25 at 2:44 P.M., Resident #6 confirmed she lost her dentures at an unknown time and the facility had not assisted her with a replacement. During an interview with the Director of Nursing (DON) on 09/09/25 at 4:25 P.M. she verified Resident #6 has not been seen by a dentist since 01/19/24, and was not aware the resident's dentures were missing. She added that Resident #6 would be seen on-site by a dentist on 09/30/25.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to implement restorative programs following completion of therapy services as recommended. This affected one (#11) of two residents reviewed for therapy services. The facility census was 112. Findings Include:Review of Resident #11's medical record revealed an initial admission date of 08/19/24 with a re-admission date 05/24/25. Diagnoses including but were not limited to orthopedic care, fracture of the left femur, high blood pressure, spinal stenosis, and dementia.Review of Resident #11's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had impaired cognition with a Brief Interview of Mental Status (BIMS) score of nine out of a possible 15, and was independent with ambulation, transfers, and personal hygiene. Resident #11 had a history of falls.Review of Resident #11's progress notes dated 05/19/25 at 8:16 A.M. revealed Resident #11 reported to the day shift nurse during morning medication administration that Resident #11 slipped on water on the floor in his room and fell on his left knee during the night. Further review revealed Resident #11 was assessed by Licensed Practical Nurse (LPN) #327 with swelling and pain to left knee was noted. LPN #327 notified the physician and received an order to send Resident #11 to the hospital for further evaluation and treatment.Review of Resident #11's facility fall investigation dated 05/19/25 revealed Resident #11 reported to the day shift nurse (LPN #327) he slipped on water and fell on his left knee. Resident #11 had been carrying a wash basin of water to the bathroom to dump in the sink. Resident #11's neighbor was in the bathroom at the time and closed the door to Resident #11's room causing Resident #11 to drop the basin of water on the floor, and causing Resident #11 to slip and fall on left knee. As a result of the incident the facility recommended therapy evaluations for both physical therapy (PT) and occupational therapy (OT) upon readmission to the facility.Review of Resident #11's PT evaluation and Discharge summary dated [DATE] to 06/23/25 revealed Resident #11 reached maximum potential for ambulation and was discharged from PT services with a restorative program recommendation for ambulation. Further review revealed an ambulation restorative program was implemented on 05/29/25, with daily participation by Resident #11 noted.Review of Resident #11's OT evaluation and Discharge summary dated [DATE] to 06/23/25 revealed Resident #11 reached maximum potential for activities of daily living (ADLs) tasks and was discharged from OT services with an ADLs restorative program recommended. Further review revealed Resident #11 did not have an ADLs restorative program implemented for ADLs tasks.An interview on 09/11/25 at 1:36 P.M. with Restorative Aid (RA) #527 revealed Resident #11 participated in the ambulation restorative program on a daily basis. RA #527 stated Resident #11 has never had an ADLs restorative program to complete.An interview on 09/11/25 at 2:36 P.M. with Therapy Director #550 revealed there was an ADLs restorative program recommended following Resident #11's discharge from OT services on 06/23/25. The program was for ADLs tasks including personal hygiene, dressing, and grooming.An interview on 09/11/25 at 2:56 P.M. with Assistant Director of Nursing (ADON) #311 confirmed Resident #11 did not have an ADLs restorative program implemented. ADON #311 stated when OT wrote the recommended ADLs program and completed the recommended evaluation for the ADLs program on 06/26/25, the evaluation was not locked until 07/02/25 by OT. ADON #311 stated he did not review the list of completed/locked evaluations after implementing Resident #11's ambulation restorative program.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on facility infection tracking and monitoring records, and staff interview, the facility failed to properly monitor and address patterns and trends of known infections. This had the potential to affect all 112 residents in the facility. The census was 112. Findings Include:Review of the facility infection control log, dated June 2025, revealed there were two urinary tract infections on one hallway and 12 total skin infections throughout the facility, including three in one unit and three on a separate unit. Review of facility infection control log, dated July 2025, revealed two fungal infections on one unit, two osteomyelitis infections on another unit, three skin infections on a third unit, and two more fungal infections on a fourth unit. Review of facility infection control log, dated August 2025, revealed three urinary tract infections, two of which the organism was extended-spectrum beta-lactamase (ESBL), in one unit, and two respiratory infections in a separate unit. Review of facility infection control logs and documentation, dated June 2025 to August 2025, revealed there was no documentation to support the facility had addressed the above listed infection patterns/trends. There was no documentation to support any staff education and/or monitoring/auditing of care was completed to reduce the likelihood of these infections spreading.Interview with Registered Nurse (RN) #248 on 09/11/25 at 10:58 A.M. confirmed she has not implemented any staff education, monitoring, or auditing of the patterns/trends listed above. She defined a pattern/trend to be two or more of the same infections/infection areas in the same unit. She confirmed there were patterns/trends and they have not addressed it.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, resident and staff interview, review of pest control records, and facility policy review, the facility failed to maintain an effective pest control program. This deficient practice affected three (#3, #52, and #93) of 112 residents observed for environment and pest control. The facility census was 112.Findings Include:An observation on 09/08/25 at 10:15 A.M. revealed Resident #105 sitting at edge of the bed looking out the window. There were multiple house flies noted on the windowsill and bed covers.An observation on 09/08/25 at 11:25 A.M. revealed Resident #52 sitting in a wheelchair in her room awaiting lunch meal service. There were several house flies observed in the room. Resident #52 would occasionally swat at one house fly as it flew around her face.An observation on 09/08/25 at 2:21 P.M. revealed Resident #3 resting in bed with the bed covers pulled up to his chest area. There were multiple house flies on the bed covers and windowsill.An observation on 09/09/25 at 11:00 A.M. revealed Resident #3 sitting up in bed with the bed covers pulled up to cover his lower body. There were multiple flies on the bed covers and flying around Resident #3's face.An interview on 09/09/25 at 11:05 A.M. with Resident #3 revealed there were always flies in his room and he does not like the flies being in his room.An interview on 09/09/25 at 2:00 P.M. with Certified Nurse Aide (CNA) #343 confirmed there are flies throughout the facility, especially in Resident #3's and Resident #105's rooms. CNA #343 stated sometimes there was a pest control company that came to the facility.Review of the facility's pest control visit summary dated 03/25/25 to 09/08/25 revealed the facility was treated for fly activity in the kitchen and in several resident rooms. Further review revealed the pest control company noted the contributing factor for fly activity was poor sanitation in resident bathrooms and recommended cleaning and sanitize the bathrooms of urine and fecal matter on a regular basis.Review of the facility's pest control policy dated 03/05/25 revealed the purpose was to provide an environment free of pests. The facility will have a pest control contract that provides frequent treatment of the environment for pests. It will allow for additional visits when a problem is detected. Monitoring of the environment will be done by the facility's staff. Pest control problems will be reported promptly.