

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365489	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/07/2026
NAME OF PROVIDER OR SUPPLIER Edgewood Manor Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1330 S Fulton St Port Clinton, OH 43452	
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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and facility policy review, the facility failed to ensure a resident's safety during perineal care. Actual harm occurred on 06/27/26 at 11:29 P.M. when Resident #69 was receiving perineal care from one staff member and the staff turned to obtain a washcloth from the basin and the resident rolled off the bed onto the floor. Resident #69 sustained a laceration to the left eyebrow that required skin glue to close and sustained left periorbital soft tissue swelling and hematoma. This affected one, (Resident #69) of one reviewed for falls. Findings included: Review of Resident #69's medical record revealed an admission date of 02/26/25. Diagnoses included brief psychotic disorder, dementia with agitation, anxiety, history of embolism, and abnormal posture. Review of Resident #69's care plan dated 02/27/25 revealed she was at risk for falls related to agitation, bladder and/or bowel incontinence, decreased strength and endurance, generalized weakness, impaired cognition with decreased safety awareness, and needed assistance with activities of daily living. Interventions were to implement preventative fall interventions and devices. Review of Resident #69's Fall Occurrence Evaluation dated 02/04/26 at 12:45 A.M. revealed the resident had a history of falling from the bed. The Certified Nursing Assistant (CNA) went into Resident #69's room to complete rounding and found the resident on the floor. Upon entry Resident #69 was lying on her left side with head against the dresser and her knees tucked under the heating unit. There was a moderate amount of blood on the floor under her head. Her pull tab alarm was still attached to her shirt on the floor and was not activated due to still being connected. Resident #69 was unable to verbalize due to cognitive issues. Resident #69 was able to move extremities and neck without significant pain or difficulties. Interventions were to implement diversional activity items and nonskid footwear. Review of Resident #69's Fall Risk Evaluation dated 02/04/26 revealed the resident had a history of falls and she would overestimate and forget her limits. She was at high risk for falls. Review of Resident #69's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had severely impaired cognition. Resident #69 was dependent on staff for rolling left and right, rolling from lying on back to left and right side, and returning to lying on back on the bed. Review of Resident #69's progress note dated 06/28/26 at 1:27 A.M. revealed the Director of Nursing (DON) was notified of an issue with the mattress. After approval, a floor mat was placed and a regular mattress placed to prevent any other issues due to the resident being in bed routinely. Review of Resident #69's Fall Occurrence Note dated 06/28/26 at 1:31 A.M. revealed the CNA was completing check and change and the bed was in the raised position. The CNA turned to get her cleaning products and the resident rolled off the bed. When the fall occurred the air mattress looked half deflated. The resident description of the fall revealed the resident was alert and there was an open area to the left eyebrow. The bleeding was controlled. The incident occurred on 06/27/26 at 12:00 A.M. Review of (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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Resident #69's Fall Incident report dated 06/28/26 untimed, revealed the CNA alerted the nurse to come to her room as she indicated the resident had rolled out of bed. Upon entering the resident's room, the resident was noted to be on the floor next to the bed. Resident #69 was alert and responsive. It was noted that Resident #69 had a laceration to left side of her head. The physician was notified and the resident was transferred to the emergency room for an evaluation. Upon interview with nursing assistant, she indicated that she was providing incontinence care and she turned to obtain a washcloth from the basin and during that time the resident moved herself in bed and rolled out onto the floor. The aid indicated she was unable to hold the weight of the resident as she was rolling herself out of bed. The root cause was the resident exhibited a new behavior during care and repositioned self in bed to where she rolled out of bed. Previous interventions were to place bed against the wall, clear pathways, diversional activities, call light in reach, maintain needed items within reach, non-skid footwear when out of bed and prior therapy referral. Immediate intervention was implemented to place a mat on the floor and additional intervention added for the resident to be a two person assist with bed mobility. Review of Resident #69's progress note dated 06/28/26 at 3:54 A.M. revealed the resident was sent to the emergency room for a witnessed fall. Resident #69 hit her head on the floor when she rolled out of bed and had an open area to the eyebrow. The residents' son was notified prior to transport. The resident was transferred back to the facility with no new orders. The residents' laceration was glued. Review of Resident #69's hospital emergency room notes dated 06/28/26 revealed the resident was diagnosed with a fall, head injury and facial laceration. The resident had skin glue placed over the laceration to the left side of the face. Review of the computed tomography (CT) head scan revealed the resident suffered from left periorbital soft tissue swelling and hematoma. Observation on 06/28/26 at 10:10 A.M. of Resident #69 revealed the resident was lying in bed sleeping. The resident had a mat on the floor at bedside, was on a regular mattress, and the bed was in a low position. Observation on 06/29/2026 at 12:30 P.M. of Resident #69 revealed the resident was sitting in a chair in the memory care unit lounge area with significant bruising to left side of face and orbital area. Interview on 06/29/26 at 12:31 P.M. with Licensed Practical Nurse (LPN) #148 and LPN #158 revealed Resident #69's face was badly bruised due to an issue with her air mattress, and she rolled out of bed and was sent to the hospital on the night shift. Interview with the DON on 06/29/26 at 12:59 P.M. denied there was an issue with the functionality of Resident #69's air mattress. The DON stated the nursing documentation regarding the resident's fall and malfunctioning air mattress was a mistake and the nurse was writing a letter to that fact. The DON verified she was notified by text during the night of the incident. Telephone interview with CNA #140 on 06/29/26 at 1:40 P.M. revealed on 06/28/26 she was in Resident #69's room for a check and change. All supplies were gathered on the bedside table, and she had raised the resident's bed in high position to accommodate the incontinent brief change. CNA #140 stated she turned away from the resident to reach for her supplies and out of the corner of her eye she saw the resident rolling toward her and then fell off the bed onto the floor. The aide stated she attempted to grab the resident's shirt but was unable to hold onto the resident. CNA #140 revealed the resident was lying on an air mattress which was half inflated and she felt that may have contributed to the fall. CNA #140 confirmed that the DON was contacted and ordered to remove the air mattress. Review of Maintenance Director #113's note provided by the facility revealed he tested Resident #69's air mattress on 06/29/26 and found the mattress to be in proper working order. Interview on 06/30/26 at 7:15 A.M. with the Administrator, Corporate Nurse #203, and Regional Nurse #204 revealed they felt Resident #69's fall was due to her fault due to a new behavior exhibited by the resident of rolling out of bed. They stated the CNA turned to obtain supplies when the resident rolled out of bed onto the floor and due to the resident being (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	heavier than the CNA the aide was unable to stop the forward motion of the resident. Interview with the Administrator on 06/30/26 at 12:34 P.M. confirmed there was no physician order for the air mattress the facility had placed on Resident #69's bed, but it was implemented as a nursing intervention due to the resident's comorbidities and her risk for possible skin breakdown. The Administrator also confirmed there was no care plan found related to the use of an air mattress with specific goals or interventions for Resident #69. The Administrator confirmed the air mattress use was resolved on 06/29/26. Inspection of the air mattress in question was not obtained as the mattress had been removed from Resident #69's bed and the surveyor was unsure which mattress was actually used for Resident #69. Review of the facility policy titled Falls dated 09/2021 revealed based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falls.		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, review of facility staffing, and review of facility policy, the facility failed to ensure sufficient dietary staff were available to timely [NAME] the dietary needs of the residents. The facility's failure to provide adequate dietary staffing had the potential to affect all residents, as the facility identified no residents who did not receive meals and food services from the facility kitchen. The facility census was 71. Findings include: Observation on 06/28/26 at 7:50 A.M. revealed an insufficient number of dietary staff available to complete meal preparation, tray assembly, and meal distribution. Dietary [NAME] #119 could not be located by Dishwasher #170. It was determined that Dietary [NAME] #119 had walked off the job, and the Dietary Manager (DM) #106 was enroute to the facility to complete breakfast preparation. Observation on 06/28/26 at 7:55 A.M. revealed the posted breakfast meal schedule as follows: South Front, 7:40 A.M.; South Back, 7:50 A.M.; North Front, 8:05 A.M.; North Back, 8:15 A.M.; and Dining Room, 8:30 A.M. Meal service was delayed beyond the facility's scheduled mealtimes due to inadequate staffing. Observation on 06/28/26 at 8:10 A.M. revealed that no one was preparing the breakfast meal. The only dietary staff member present working in the kitchen was Dishwasher #170. Observation on 06/28/26 at 9:00 A.M. revealed that residents on the hall and residents in the dining room had still not received breakfast. Observation on 06/28/26 at 9:15 A.M. revealed that random nursing staff served beverages to residents in the hallways and dining room while they continued to wait for breakfast. Observation on 06/28/26 at 9:45 A.M. revealed that three random residents in the dining room received their breakfast. Observation on 06/28/26 at 10:00 A.M. revealed the final hallway trays were delivered. Interview on 06/28/26 at 7:50 A.M. with Dishwasher #170 revealed that the department routinely operated short-staffed, resulting in delayed meal service and difficulty completing assigned duties within established time frames. Interview on 06/28/26 at 8:15 A.M. with facility Administrator revealed the facility had just recently had a large number of dietary staff quit. The facility is in the process of interviewing to fill all dietary vacancies. Interview on 06/28/26 at 8:30 A.M. with DM #106 revealed she was a new hire and that staffing was a significant issue. DM #106 confirmed that staffing shortages had contributed to delayed meal service. DM #106 further stated that staff were required to perform multiple job responsibilities simultaneously because there were not enough employees scheduled. Review of the dietary scheduling for 06/28/28 revealed there should have been one-AC morning cook from 6:00 A.M. to 2:30 P.M., one-A1 dietary morning aide from 7:00 A.M. to 2:30 P.M., and one-DW dishwasher from 7:00 A.M. to 2:30 P.M. Facility policy entitled Facility Nutrition Program revised September 2021, states, the food service manager who may be a working supervisor will oversee the activities and functions of the kitchen staff (i.e., those responsible for storing, preparing, and delivering meals, including food storage and preparation, sanitation issues, personnel matters, and menu planning and preparation.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, staff interview, and policy review the facility failed to ensure dietary staff verified the final cooking temperature of potentially hazardous food prior to placing the food into hot holding. This had the potential to affect all 71 residents receiving meals prepared by the dietary department. The census was 71. Findings include: Observation of lunch preparation on 06/28/26 at approximately 12:30 P.M., revealed the facilities business manager (BM) #104 acting as dietary staff transferred cooked hamburgers directly from the grill to the steam table without obtaining or documenting the internal temperature of the hamburgers prior to placement into hot holding. Interview on 06/28/26 at approximately 12:30 P.M. during observation with the Dietary Manager (DM) #106 confirmed the hamburgers had not been temperature checked before being placed in the steam table and acknowledged the internal temperature should have been verified before service. During an interview on 06/28/26 at approximately 12:30 P.M., the Dietary Manager #106 confirmed the facility policy required staff to verify and document the final internal cooking temperature of cooked potentially hazardous foods prior to placing them into hot holding. The Dietary Manager #106 acknowledged staff failed to follow the facility's food safety procedures during the observed meal service. Review of the facility's policy, titled Food Handling revised September 2021, indicated all employees who handle, prepare or serve food will be trained in the practices of safe food handling and preventing foodborne illnesses. Functioning of the refrigeration and food temperatures will be monitored and documented according to state-specific requirements. Potentially hazardous foods will be cooked to the appropriate internal temperature and held at those temperatures for the appropriate length of time to destroy pathogenic microorganisms.		

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observation, staff interview, and facility policy review, the facility failed to serve meals in accordance with established meal schedules. This deficient practice had the potential to affect all 71 residents receiving meals from the dietary department. The census was 71. Findings include: Interview with the facility Administrator on 06/28/26 at 10:45 A.M. verified the lunch service would be pushed back to start serving at 12:45 P.M. due to the delayed breakfast times. Administrator verified with surveyor that all Residents and staff would be notified. Meal service was delayed beyond the facility's scheduled mealtimes due to inadequate staffing that affected the delivery of breakfast. Observation on 06/28/26 of the lunch tray line began at approximately 1:30 P.M. which was 45 minutes passed the established 12:45 P.M. start time. The last set of hallway trays did not arrive at the nursing floor until approximately 2:10 P.M. and the dining room Residents were served at 2:15 P.M. Interview on 06/28/26 at 8:30 A.M. with DM #106 revealed she was a new hire and that staffing was a significant issue. DM #106 confirmed that staffing shortages had contributed to delayed meal service. DM #106 further stated that staff were required to perform multiple job responsibilities simultaneously because there were not enough employees scheduled. DM revealed the dietary department was operating with insufficient staff, resulting in delays in tray assembly and meal distribution. DM #106 stated staffing shortages contributed to residents receiving meals later than the facility's established meal schedule. Review of the facilities posted mealtimes revealed the posted lunch meal schedule as follows: South Front, 11:40 A.M.; South Back, 11:50 A.M.; North Front, 12:05 P.M.; North Back, 12:15 P.M.; and Dining Room, 12:30 P.M.		

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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 maintain sanitary conditions during food preparation and meal service. This had the potential to affect all 71 residents receiving meals prepared by the dietary department. The census was 71. Findings include: Findings include: Observations of meal preparation and service on 06/28/26 from approximately 12:30 P.M. until 2:15 P.M. revealed in addition to the dietary staff, the facility administration assisted with meal preparation, cooking, and food distribution. Two non-dietary staff, Business Office Manager #104 and Regional Nurse #204 were observed to enter the kitchen/cooking area and neither staff were observed to perform hand hygiene when entering the kitchen prior to performing kitchen food prep task. BM #104 and Regional Nurse #204 then began preparing tomatoes, onions and lettuce with gloves on. During the meal preparation observation on 06/28/26 from 12:30 P.M. to 2:15 P.M. The following were observed by the specified staff members: BM #104 was observed to handle raw food products and subsequently handled food utensils without removing gloves, performing hand hygiene, or changing gloves. BM #104's clothing came into direct contact with food during meal preparation. BM #104 was also observed to touch door handles, carry fruit cups, touch outside of the hamburger bun packaging, while wearing food service gloves and return to food preparation task without changing gloves or performing hand hygiene. BOM #104 and Regional Nurse #204 were observed to place raw chicken into the deep fryer and subsequently handled raw French fries using the same gloves without changing gloves or performing hand hygiene. Observation on 06/28/26 at 1:30 P.M. DM #106 was putting frozen chicken tenders into the fryer with gloves on, then put her same gloved hand into the frozen French fries to put them in the fryer. DM #106 did not change her gloves or perform hand hygiene and was observed to grab the serving scoops with the wqm3 gloved hands. DM #106 was then observed handling a block of cheese without performing hand hygiene or changing her gloves and then placed the block of cheese on the outside of the cheese wrapper and not on a clean food preparation surface. DM #106 was then observed removing her gloves, opening the garbage can, and donning new gloves without performing hand hygiene. DM #106 was then observed pressing food up against her uniform and then plating the food. DM #106 was observed wiping her gloved hands on her forehead and then grabbing the serving utensil to remove French fries out of the fryer basket. The French fries were then placed then on a plate to be served to a resident without DM #106 removing gloves and performing hand hygiene. During the tray line service on 06/28/26 from approximately 1:40 P.M. to 2:15 P.M. DM #106 was observed to touch her face, eyeglasses, and body while wearing serving gloves and continued handling food without changing gloves or performing hand hygiene. Interviews conducted with DM #106 at the time of the observations acknowledged, verified the observed practices and confirmed gloves should be changed and hand hygiene performed whenever gloves become contaminated, after touching environmental surfaces, after handling raw animal products, and before resuming food preparation. DM# 106 confirmed staff are expected to follow facility policies regarding hand hygiene, glove use, prevention of cross-contamination, and sanitary food handling practices. DM #106 acknowledged the observed practices were inconsistent with facility policy and accepted food safety standards. Review of the Food Handling policy dated September 2021 revealed that food will be stored, prepared, handled and served so that the risk of foodborne illness is minimized.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, staff interview, resident interview, medical record review, and review of facility policy, the facility failed to ensure the physical environment was maintained in a clean, sanitary, functional, and comfortable manner for residents residing outside of the memory care unit. This deficient practice had the potential to affect all residents residing outside of the memory care unit. The facility census was 71. Findings include: Observation on 06/28/26 at 7:51 A.M. revealed the flooring throughout the 100 Hall was excessively sticky. Interview on 06/28/26 at 7:51 a.m. with Licensed Practical Nurse (LPN) #163 confirmed the flooring throughout the 100 Hall was excessively sticky. Observation on 06/28/26 at 7:55 A.M. revealed the cove base in the common area of the 100 Hall was peeling away from the wall, exposing broken and cracked drywall. Interview on 06/28/26 at 7:57 A.M. with LPN #163 confirmed the cove base in the common area of the 100 Hall was peeling away from the wall and exposing broken and cracked drywall. Observation on 06/28/26 at 7:55 A.M. revealed the chair rail in the common area of the 100 Hall contained peeling and chipped paint. Interview on 06/28/26 at 7:57 A.M. with LPN #163 confirmed the chair rail in the common area of the 100 Hall contained peeling and chipped paint. Observation on 06/29/26 at 7:00 A.M. revealed the floor near the fire door on the 100 Hall contained a substantial accumulation of debris, including dust, hair, and unidentified dirt and debris. Interview on 06/29/26 at 7:02 A.M. with LPN #134 confirmed the floor near the fire door on the 100 Hall contained a substantial accumulation of debris, including dust, hair, and unidentified dirt and debris. Review of the undated facility policy titled Housekeeping/Environmental Services revealed cleaning schedules are developed and implemented to ensure each area of the facility is maintained in a safe, clean, and comfortable manner.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and policy review, the facility failed to ensure respect and dignity was maintained during meal service. This affected two residents (#26 and #32) out of 12 residents observed during lunch meal service. The facility census was 71. Review of the medical record revealed Resident #26 was admitted to the facility on [DATE]. Diagnoses included dementia, dysphagia, Alzheimer's disease and anxiety. Review of the Minimum Data Set (MDS) assessment for Resident #26 revealed a Brief Interview for Mental Status (BIMS) score of 00, indicating severe cognitive impairment. Review of the medical record revealed Resident #32 was admitted to the facility on [DATE]. Diagnosis included dementia, muscle weakness and anxiety. Review of the MDS assessment for Resident #32 revealed a BIMS score of three, indicating severe cognitive deficit. Observation on 06/28/26 at 1:55 P.M. of lunch service revealed 12 residents in the dining room on the South Hall. Resident #26 was seated in a chair with a bedside table in front of her. Certified Nursing Assistant (CNA) #128 was standing on the other side of the bedside table. CNA #128 was observed standing while feeding Resident #26. Further observation on 06/28/26 at 2:00 P.M. of lunch service revealed Resident #32 was seated in a chair at a dining table. CNA #128 completed assisting Resident #24 with lunch service then moved over to assist Resident #32. CNA #128 was observed standing to the right of Resident #32 while feeding her. Interview on 06/28/26 at 2:05 P.M. with CNA #128 verified she assisted both Resident #24 and Resident #32 with lunch. CNA #128 also verified she was standing while assisting both residents with their lunch. Review of policy Dignity undated, revealed residents are to always be treated with respect and dignity.		

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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, staff interview, resident interview, medical record review, and review of facility policy, the facility failed to ensure the physical environment was maintained in a clean, sanitary, functional, and comfortable manner for one resident (#79) of five reviewed for Activities of Daily Living (ADLs). The facility census was 71. Findings include: Review of the medical record for Resident #79 revealed an admission date of 06/25/26 with diagnoses that included major depressive disorder, Type II Diabetes Mellitus (DM2), anxiety disorder, psychosis, personal history of suicidal behavior, atherosclerotic heart disease of the native coronary arteries, personal history of transient ischemic attack (TIA), polyneuropathy, urinary retention, acquired absence of other toes, and chronic pain. Review of Resident #79's admission Minimum Data Set (MDS) assessment, dated 06/25/26, revealed the resident was unable to complete the Brief Interview for Mental Status (BIMS). Observation on 06/28/26 at 11:14 A.M. revealed Resident #79's bed linens were soiled with unidentified brown and red substances throughout. Interview on 06/28/26 at 11:15 a.m. with Resident #79 revealed he was dissatisfied with the condition of his personal hygiene, clothing, and bed. Interview on 06/28/26 at 11:17 a.m. with Licensed Practical Nurse (LPN) #163 confirmed Resident #79's bed linens were soiled with unidentified brown and red substances throughout. Review of the undated facility policy titled Housekeeping/Environmental Services revealed cleaning schedules are developed and implemented to ensure each area of the facility is maintained in a safe, clean, and comfortable manner.		

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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 observation, resident interview, staff interview, review of medical record, and review of facility policy, the facility failed to ensure one resident (#79) received assistance with Activities of Daily Living (ADL) . This affected one of five reviewed for ADL's. The facility identified that all facility residents require assistance with ADLs. The facility census was 71. Findings Include:Review of the medical record for Resident #79 revealed an admission date of 06/25/26 with diagnoses including major depressive disorder, Type II Diabetes Mellitus (DM2), anxiety disorder, unspecified psychosis, personal history of suicidal behavior, atherosclerotic heart disease of the native coronary arteries, personal history of transient ischemic attack (TIA), polyneuropathy, urinary retention, acquired absence of other toes, and chronic pain. Review of the admission Minimum Data Set (MDS) assessment, dated 06/25/26, revealed the Brief Interview for Mental Status (BIMS) was not completed due to the resident's recent admission to the facility. Observation on 06/28/26 at 11:13 A.M. revealed Resident #79 appeared disheveled and poorly groomed. The resident's shirt contained miscellaneous debris, including food residue, dry skin, and unidentified debris. Concurrent observation revealed the resident's beard was dirty and contained food residue and other debris. Interview with Resident #79 on 06/28/26 at 11:14 A.M. revealed the resident had not received a shower or had his clothing changed since his admission on [DATE]. The resident stated he requested a shower during the evening of 06/27/26; however, a shower was not provided, and he was not informed of the facility's shower schedule. The resident stated he was unhappy with the condition of his clothing and beard and reported that it bothered him. Interview with Licensed Practical Nurse (LPN) #163 on 06/28/26 at 11:17 A.M. verified Resident #79 appeared disheveled and poorly groomed. LPN #163 confirmed the resident's shirt was soiled with miscellaneous debris and food residue and that the resident's beard was dirty. Review of the facility's undated policy titled Activities of Daily Living (ADLs) revealed residents who are unable to independently perform activities of daily living will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. The policy further stated that appropriate care and services will be provided to residents who are unable to carry out ADLs independently.		

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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 record review, staff and resident interview, and facility policy review, the facility failed to ensure foley catheters were secured. This affected two residents (#22 and #51) of two residents reviewed for catheter securement devices. The facility census was 71. Findings Include: 1. Review of Resident #22's medical record revealed an admission date of 06/05/26. Diagnoses included benign prostatic hyperplasia without lower urinary tract symptoms, obstructive uropathy, urinary retention, hypertension, Type II Diabetes, sepsis, emphysema, and acute respiratory failure with hypoxia. Review of Resident #22's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 had intact cognition and had an indwelling catheter. Review of Resident #22's care plan dated 06/16/26 revealed Resident #22 had an indwelling foley catheter due to an impaired genitourinary status related to benign prostatic hyperplasia (BPH), obstructive uropathy, and urinary retention. Observation on 06/30/26 at 7:00 A.M. of Resident #22's urinary catheter tubing revealed Resident #22 did not have a urinary catheter securement device in place. Interview on 06/30/26 at 7:07 A.M. with Certified Nursing Assistant (CNA) #161 confirmed Resident #22's Foley catheter was not secured and acknowledged the catheter should have been stabilized using an appropriate securement device in accordance with facility policy. 2. Review of Resident #51's medical record revealed an admission date of 06/18/26. Diagnoses included neuromuscular dysfunction of the bladder, borderline personality disorder, bipolar disorder, and anxiety disorder. Review of Resident #51's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 had intact cognition and had an indwelling catheter. Review of Resident #51's care plan dated 06/19/26 revealed Resident #51 had an indwelling foley catheter due to urinary retention and neurogenic bladder. Observation on 06/30/26 at 7:25 A.M. of Resident #51's urinary catheter tubing revealed Resident #51 did not have a urinary catheter securement device in place. Interview on 06/30/26 at 7:30 A.M. with Resident #51 revealed that her foley catheter had not been secured to her leg since she was admitted to the facility. Interview on 06/30/26 at 7:36 A.M. with Certified Nursing Assistant (CNA) #161 confirmed Resident #51's Foley catheter was not secured and acknowledged the catheter should have been stabilized using an appropriate securement device in accordance with facility policy. Review of the facility's policy titled, Catheter Care, Urinary revised September 2023, indicated ensuring that the indwelling urinary catheters remain secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the Resident's inner thigh utilizing a leg band).		

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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. Based on observation, resident and staff interview, medical record review, review of facility policy, review of distributor documentation, and review of manufacturer documentation, the facility failed to ensure respiratory care was provided consistent with professional standards of practice for one resident (#21) of one resident reviewed for oxygen. The facility identified 10 residents (#9, #13, #14, #20, #21, #28, #43, #53, #57, and #61) with physician orders for oxygen. The facility census was 71. Findings Include: Review of the medical record for Resident #21 revealed an admission date of 07/31/24 with diagnoses including chronic obstructive pulmonary disease (COPD), generalized muscle weakness, history off falling, unspecified abnormalities of gait and mobility, acute respiratory failure, obesity, gastro-esophageal reflux disease (GERD), congestive heart failure (CHF), obstructive sleep apnea (OSA), depression, anxiety, hyperlipidemia, hypertension (HTN), and insomnia. Review of the most recent quarterly Minimum Data Set (MDS) assessment, dated 04/22/26, revealed a Brief Interview of Mental Status (BIMS) score of 15, indicating Resident #21's cognition was intact. Further review of this MDS assessment revealed Resident #21 required assistance with all functional abilities and was on continuous oxygen therapy. Review of the medical record for Resident #21 revealed a physician order, dated 07/17/24, for oxygen to be administered at five liters per minute (L/min) via nasal cannula (a lightweight, flexible plastic device used to deliver supplemental oxygen to people who have difficulty breathing). Review of the medical record for Resident #21 revealed a physician order, dated 07/20/26, to change oxygen tubing and set up, every day shift every Friday for oxygen. Observation on 06/28/26 at 8:32 A.M. of Resident #21's oxygen condenser revealed a 350 milliliter (mL) bottle of sterile water for inhalation, dated 06/19/26, that was empty and not humidifying the resident's oxygen. Interview on 06/28/26 at 8:36 A.M. with Licensed Practical Nurse (LPN) #163 verified Resident #21's oxygen condenser contained a 350mL bottle of sterile water for inhalation, dated 06/19/26, was empty and not humidifying the resident's oxygen. Further interview with LPN #163 revealed the oxygen tubing and set-up was physician-ordered to be changed every Friday, and the set-up included the 350mL bottle of sterile water for inhalation. LPN #163 stated the bottle should have been changed on 06/26/26. Interview on 06/28/26 at 3:59 P.M. with the Director of Nursing (DON) revealed the 350mL bottle of sterile water for inhalation is supposed to be changed when empty. Interview on 06/28/26 at 4:21 P.M. with Clinical Program Specialist (CPS) #203 revealed the 350mL bottle of sterile water for inhalation is supposed to be changed when empty. Interview on 06/29/26 at 6:52 A.M. with LPN #152 revealed the 350mL bottle of sterile water for inhalation is supposed to be changed when empty and is part of the oxygen set-up that is physician-ordered to be changed every Friday on day shift. Interview on 06/29/26 9:20 A.M. with Resident #21 revealed his 350mL bottle of sterile water for inhalation was not changed when it was empty. Resident #21 further stated that when his 350mL bottle of sterile water for inhalation was empty, his nose was dry and irritated. Resident #21 stated he was uncomfortable during this time. Review of the facility policy titled, Oxygen Administration, dated September 2021, revealed oxygen therapy is the administration of oxygen at concentrations greater than room air with the intent of treating or preventing the symptoms and manifestations of hypoxemia. Possible complications of oxygen therapy include bacterial contamination associated with certain nebulizer and humidifiers may occur.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, resident interview, staff interview, medical record review, and review of facility policy, the facility failed to ensure medications were stored in a safe and secure manner this affected one resident (#21). This had the potential to affect three residents (#36, #42, and #78) who were identified by the facility as independently ambulatory and cognitively impaired. The facility census was 71. Findings Include: Review of the medical record for Resident #21 revealed an admission date of 07/31/24 with diagnoses including chronic obstructive pulmonary disease (COPD), generalized muscle weakness, history of falling, abnormalities of gait and mobility, acute respiratory failure, obesity, gastroesophageal reflux disease (GERD), congestive heart failure (CHF), obstructive sleep apnea (OSA), depression, anxiety, hyperlipidemia, hypertension (HTN), and insomnia. Review of the most recent Quarterly Minimum Data Set (MDS) assessment, dated 04/22/26, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating cognition was intact. The MDS further revealed Resident #21 required staff assistance with all activities of daily living and received continuous oxygen therapy. Review of the physician's orders revealed an order, dated 05/12/25, for Incruse Ellipta Inhalation Aerosol Powder Breath Activated 62.5 micrograms per actuation (mcg/act), with instructions to inhale one puff orally once daily for COPD maintenance. Observation on 06/29/26 at 9:25 A.M. revealed a 30-dose Incruse Ellipta 62.5 microgram per actuation (mcg/act) inhaler, with three doses remaining, lying on Resident #21's bed. The inhaler was readily accessible and was not secured in accordance with the facility's medication storage policy. Interview with Resident #21 on 06/29/26 at 9:25 A.M. revealed the facility routinely left the Incruse Ellipta inhaler in the resident's room after administration. Interview with Licensed Practical Nurse (LPN) #168 on 06/29/26 at 9:26 A.M. confirmed the Incruse Ellipta inhaler, with three doses remaining, was on Resident #21's bed. LPN #168 further confirmed Resident #21 did not have a physician's order authorizing self-administration or self-storage of the medication. Review of the facility policy titled, Storage of Medications, dated 09/01/21, revealed medications are to be stored in a safe, secure, and orderly manner. The policy further stated that drugs shall be stored in cabinets, drawers, carts, or automated dispensing systems and that each resident's medications shall be assigned to an individual cubicle, drawer, or other designated holding area to prevent the possibility of medications being mixed or accessed by other residents.		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and facility policy review, the facility failed to ensure routine dental care was provided. This affected one resident (#24) out of one reviewed for dental care services. The facility census was 71. Findings Include: Review of the medical record revealed Resident #24 was admitted to the facility on [DATE]. Diagnoses included metabolic encephalopathy, dysphagia, and psychosis, major depressive disorder, Alzheimer's, and Type Two Diabetes. Review of the quarterly Minimum Data Set (MDS) assessment for Resident #24 dated 04/03/26 revealed a Brief Interview for Mental Status (BIMS) score of 00, indicating severe cognitive deficit. Function abilities included partial to moderate assistance with personal and oral hygiene. Review of the revised care plan for Resident #24 dated 03/25/25 revealed resident had a dental problem related to several teeth missing, broken and black. Interventions included providing treatment per physician order and referring to dental services. Review of physician orders entered on 03/24/25 for Resident #24 revealed consultation with follow up treatment as indicated for eye health, vision, podiatry, audiology and dental. Observation on 06/28/26 at 1:05 P.M. of Resident #24 sitting at a table in the dining area. Resident #24 started to smile and speak in Spanish. Teeth were observed to be brown, black, broken and some missing. Interview on 06/29/26 at 1:38 P.M. with Director of Social Services (DSS) #110 revealed there are no records of Resident #24 being seen by a dentist since her admission. DSS #110 further revealed Resident #24 had been seen by podiatry, audiology and visual health services. DDS #110 also stated during the interview, the dental services would be in-house on this date (06/29/26) and Resident #24 was not on their list to be seen. Interview on 06/29/26 at approximately 11:00 A.M. with DSS #110 revealed the last two visits made by the dental services to the facility were on 11/12/25 and 03/23/26. Review of the policy titled Availability of Services, Dental undated, revealed oral healthcare and dental services will be provided to each resident.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, medical record review, and review of facility policy, the facility failed to ensure Enhanced Barrier Precautions (EBP) were maintained for two residents (#5 and #63). This affected two but had the potential to affect 13 residents (#3, #4, #5, #13, #14, #16, #39, #42, #47, #51, #57, #61, and #63) identified by the facility as having physician orders for EBP. Additionally, the facility failed to ensure a urinary catheter drainage bag was not sitting on the floor. This affected one resident (#51) of three reviewed for urinary catheters. This deficient practice had the potential to affect six residents (#4, #5, #16, #39, #51, and #57) identified by the facility as having indwelling urinary catheters. The facility census was 71. Findings Include: 1. Review of the medical record for Resident #5 revealed an admission date of 01/27/26 with diagnoses that included osteomyelitis, dysphagia, gastrostomy, sepsis, schizoaffective disorder, quadriplegia, and psychosis. Review of the most recent Minimum Data Set (MDS) assessment, dated 06/13/26, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #5's cognition was intact. Further review of the MDS assessment revealed Resident #5 required assistance with all activities of daily living. Review of the medical record revealed a physician's order, dated 06/09/26, for Enhanced Barrier Precautions (EBP) every shift related to a wound and Foley catheter (a thin, flexible tube inserted through the urethra into the bladder to continuously drain urine). Observation on 06/28/26 at 11:30 A.M. revealed signage posted outside Resident #5's room indicating the resident was on Enhanced Barrier Precautions. The signage instructed everyone to perform hand hygiene before entering and upon leaving the room. It further instructed providers and staff to wear gloves and a gown while performing high-contact resident care activities, including dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, or tracheostomy), and wound care involving any skin opening requiring a dressing. The signage also instructed staff not to wear the same gown and gloves when providing care to more than one resident. Observation on 06/28/26 at 11:30 A.M. revealed Certified Nursing Assistant (CNA) #125 was in Resident #5's room changing the resident's bed linens without wearing an isolation gown. Interview on 06/28/26 at 11:31 A.M. with CNA #125 confirmed Resident #5 was on Enhanced Barrier Precautions and verified the EBP signage posted outside the resident's room. CNA #125 verified they changed Resident #5's bed linens without wearing an isolation gown. 2. Review of the medical record revealed Resident #63 was admitted to the facility on [DATE]. Diagnoses included Type Two Diabetes, cerebral infarction and chronic obstructive pulmonary disease. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the most recent completed Minimum Data Set (MDS) assessment for Resident #63 dated 04/03/26 revealed a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognition. A diabetic foot ulcer was present. Review of the revised care plan for Resident #63 dated 05/18/26 revealed impaired skin integrity related to a diabetic foot ulcer. Also included in the care plan was Resident #63 was to be in Enhanced Barrier Precautions (EBP) related to the diabetic foot ulcer wound. Review of physician orders for Resident #63 dated 06/16/26 revealed an order for EBP every shift for wound. Observation and subsequent interview on 06/29/26 at 9:50 A.M. of Certified Nursing Assistant (CNA) #160 opening the door and exiting Resident #63's room. CNA #160 stated she assisted Resident #63 with getting off the bedpan. CNA #160 verified Resident #63 was in EBP. CNA #160 also verified she did not wear Personal Protective Equipment (PPE) when taking Resident #63 off the bedpan because Resident #63 did not have a bowel movement, so Personal Protective Equipment (PPE) was not required. 3. Review of Resident #51's medical record revealed an admission date of 06/18/26. Diagnoses included neuromuscular dysfunction of the bladder, borderline personality disorder, bipolar disorder, and anxiety disorder. Review of Resident #51's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 had intact cognition and had an indwelling catheter. Review of Resident #51's care plan dated 06/19/26 revealed Resident #51 had an indwelling foley catheter due to urinary retention and neurogenic bladder. Observation on 06/28/26 at 11:18 A.M. Resident #51's urinary drainage bag was lying directly on the floor rather than being secured to the bed frame below the level of the bladder. The drainage bag remained in contact with the floor during the observation. Interview on 06/28/26 at 11:18 A.M. with Registered Nurse (RN) #157 confirmed the urinary drainage bag was resting on the floor and acknowledged it should have been secured to the bed frame to prevent contamination and maintain proper infection prevention practices. Review of the facility's policy titled, Catheter Care, Urinary revised September 2023, indicated ensuring that the indwelling urinary catheters tubing and drainage bag are kept off the floor. Review of the facility policy titled Enhanced Barrier Precautions (EBP), dated January 2024, revealed Enhanced Barrier Precautions are an infection prevention and control strategy used to reduce the transmission of multidrug-resistant organisms (MDROs). The policy indicated EBP requires the use of gowns and gloves during high-contact resident care activities for residents with known infection or colonization with a multidrug-resistant organism when Contact Precautions do not otherwise apply, (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	chronic wounds, or indwelling medical devices. The policy identified high-contact resident care activities as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, caring for or using an indwelling medical device (such as a central venous catheter, urinary catheter, feeding tube, or tracheostomy/ventilator), and performing wound care.		