STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365510	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethesda Care Center	600 N Brush St Fremont, OH 43420

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Give residents a notice of rights, rules, services and charges. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on family interview, staff interview, and review of medical records, the facility failed to ensure the resident's representative was provided requested facility policies necessary to support participation in the person-centered care planning process for Resident #63. The facility census was 82. Findings Include: Review of the medical record for Resident #63 revealed an admission date of 08/12/24 with diagnoses including chronic kidney disease stage IIIA, hypertension, hyperlipidemia, polyneuropathy, osteoarthritis, dementia, hypothyroidism, chronic pain, generalized muscle weakness, cardiac murmur, amnesia, photokeratitis, and dermatitis.Review of the Resident #63's most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of three, indicating severe cognitive impairment. Further review revealed Resident #63 required at least limited assistance with all activities of daily living, including eating, hygiene, toileting, dressing, transferring, and ambulation.Interviews conducted from 03/30/26 through 04/02/26 revealed Resident #63's daughter requested facility policies related to medication administration and bed alarms; however, the facility failed to provide the requested policies.Interview on 04/01/26 at 9:07 A.M. with the Administrator, Regional Director of Operations (RDO) #316, and Regional Director of Clinical Services (RDCS) #317 confirmed that Resident #63's daughter requested the policies and the facility did not provide them.During the exit conference on 04/02/26 at 4:00 P.M., RDO #316 again acknowledged the request was not fulfilled and stated the facility did not provide the policies due to ongoing revisions and the inability to ensure distribution of updated versions.Review of facility policies revealed no policy was available regarding the provision of facility policies to residents and/or resident representatives upon request.This deficiency represents non-compliance investigated under Complaint Number 2677052.

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, family interview, and review of the facility policy, the facility failed to ensure the physician was notified timely when a resident had a change of condition. This affected one (Resident #91) of one reviewed for notification of change. The facility census was 82.Findings include:Review of the medical record for Resident #91 revealed an admission on [DATE] and a discharge date of [DATE]. Diagnoses included Parkinson's Disease and essential hypertension.Review of the Occupational Therapy (OT) Treatment Encounter Notes dated [DATE] revealed Resident #91 had decreased alertness and lethargy during evaluation. Resident #91 was constantly falling asleep and required verbal cues to stay awake. There was no evidence the physician was notified of Resident #91's change in condition.Review of the nursing progress note dated [DATE] at 5:57 A.M. revealed Licensed Practical Nurse (LPN) #311 held Resident #91's cyclobenzaprine (muscle relaxant) 10 milligrams (mg) tablet due to Resident #91 being lethargic, unable to keep resident awake for conversation. Resident #91 stated I'm just tired. There was no evidence the physician was notified of Resident #91's change in condition and holding a medication.The nursing progress notes dated [DATE] at 1:54 P.M. revealed LPN #666 was alerted by certified nursing aides (CNAs) that Resident #91 was breathing different. LPN #666 returned to Resident #91's room to find Resident #91 unresponsive. Full code was initiated per advanced directives. LPN #666 called for crash cart and 911 to be called. Emergency Medical Services (EMS) arrived and called time of death on [DATE] at 10:15 A.M.Interview on [DATE] with Director of Nursing (DON) at 7:27 A.M. confirmed there was no documentation the physician was notified on [DATE] when OT identified a change in condition in Resident #91 and on [DATE] when LPN #311 held a medication and noted a change in condition. The DON confirmed the physician should have been notified on [DATE] and [DATE].Interview on [DATE] at 11:40 A.M. with Medical Director (MD) #313 revealed staff should notify the physician or on call Nurse Practitioner (NP) any time there was a change in condition with a resident. MD #313 confirmed if Resident #91 was presenting with lethargy and hypotension, the on call physician should have been called immediately.Review of the facility policy titled Charting and Documentation dated 07/2023 revealed the following information is to be documented in the resident medical record: treatments or services performed, changes in the resident's condition, assessment data and any unusual finding obtained during the procedure.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of Self-Reported Incident Investigation, facility investigation, medical record review, staff interview, and policy review, the facility failed to ensure one (Resident #10) was free of misappropriation of narcotic medications. This affected one, Resident #10 of one reviewed for misappropriation. This had the ability to affect 18 Residents (#4, #5, #10, #25, #27, #29, #31, #36, #37, #41, #50, #56, #57, #58, #60, #65, #68, and #70) identified as receiving narcotic medication. The facility census was 82.Findings included:Review of Resident #10's medical record revealed an admission date of 06/21/25. Diagnosis included congestive heart failure, end stage heart failure, Diabetes Mellitus Type II, and chronic obstructive pulmonary disease. Review of Resident #10's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had an intact cognitionReview of Resident #10's most recent care plan revealed she had a potential for alteration in comfort related to the disease process. Interventions included educating the resident to request pain medication before her pain became severe.Review of Resident #10's medical record revealed a physician's order dated 09/06/25 for Oxycodone HCl oral tablet five milligrams (mg) to administer two every six hours as needed (PRN) for pain level of six to 10. Review of Resident #10's Medication Administration Record dated September 2025, and October 2025 revealed the resident was administered Oxycodone HCL 5 mg two tablets on 09/09/25 at 8:01 P.M. for a pain level of four, the medication was noted to be effective. On 09/11/25 at 2:03 A.M. the resident was administered Oxycodone HCL 5 mg two tablets for a pain level of eight, the medication was noted to be effective. On 10/02/25 at 9:01 P.M. the resident was administered Oxycodone HCL 5 mg two tablets for a pain level of four, the medication was noted to be effective. Review of Resident #10's Controlled Drug Administration Record revealed Oxycodone HCL 5 mg two tablets were documented as removed from the secured narcotic lock box on the following dates and time for Resident #10; 09/06/25 at 3:00 P.M., 09/07/25 at 7:00 A.M. and 4:00 P.M., 09/10/25 at 8:05 A.M. and 10:40 A.M., 09/11/25 at 2:03 A.M. and 10:00 A.M., 09/12/25 at 7:30 A.M. and 1:00 P.M. Due to unaccounted doses of Oxycodone which were signed out the Controlled Drug Administration Record but not documented as administered on Resident #10's MAR as administered, the facility initiated an investigation. Review of the facility investigation dated 10/30/25 revealed the investigation included a local police department investigation report dated 10/30/25. The report stated a facility employee reported the theft of Oxycodone belonging to Resident #10 and it continued to be under investigation. Further review revealed Licensed Practical Nurse (LPN) #319 stated LPN #666 forgot to sign out two narcotic pills. LPN #319 revealed LPN #666 wasn't signing narcotics out. LPN #319 stated she was worried about LPN #666 because she and her boyfriend have psychiatric issues. On 10/30/25 LPN #666 had to leave early so LPN #319 signed out narcotics which LPN #666 had administered earlier in the day. LPN #319 revealed she and LPN #666 failed to count narcotics prior to her taking over the cart on night shift.Review of Resident #10's interview dated 10/31/25 revealed she did have pain. The resident pointed to her amputation and stated it was phantom pain. She revealed she took Tylenol at times but had not taken any Oxycodone in quite a while.Review of Resident #10's drug test completed on 10/30/25 revealed she was negative for opiates and Oxycodone.Review of the facility completed self-reported incident number 266988 revealed upon review of narcotic documentation, nurse was found to have signed for a narcotic on the controlled drug administration record but failed to document administration in the electronic Medication Administration Record (MAR). The nurse was suspended pending investigation. Through investigation it was noted of the 41 times PRN Oxycodone was signed out, the nurse in question signed for 35 of the removals of medication. The nurse in question had signed in the narcotic sign off book during several shifts for administration of the Oxycodone to the resident, often times, twice through the shift. Upon interview of the resident, resident stated she has pain at times to her amputation site. She stated, it's phantom pain. When asked about what she takes to help with her (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain the resident stated she took Tylenol and it is helpful. When asked if she takes anything stronger for her pain the resident stated she had taken something stronger before, but it has been a while since she has needed it. The social services designee completed Brief Interview of Mental Status (BIMs) on resident with result of 15, cognitively intact. Interview of staff member in question conducted who stated she signed the medication out in the narcotic book, and it was requested at the time of sign out by the resident. She stated each time she signed the medication out she provided the medication to the resident. The facility stated the available evidence was inconclusive, but suspected.Review of LPN #666's Disciplinary Action Report dated 11/05/25 revealed the nurse failed to properly document the administration of controlled substances on multiple occasions and shifts. A verbal warning was given on 09/25/25 and a written warning on 10/04/25. Termination was effective on 11/05/25. The letter confirmed the termination of her employment effective 11/05/25. The decision was made following repeated failures to properly document the administration of controlled substances, which violates company policy and regulatory standards. Despite prior warnings and guidance, the issue persisted and had compromised the facility compliance and patient safety protocols.Interview with the Administrator and Director of Nursing on 04/01/26 revealed neither were employed by the facility during that time and were unfamiliar with the investigation.Interview with Resident #10 on 04/01/26 at 2:11 P.M. revealed she was aware a nurse had stolen some of her Oxycodone and she volunteered to take a blood test which revealed she had not been administered Oxycodone in a long time.Email interview with the Healthcare Investigation Specialist on 04/06/26 at 1:30 P.M. revealed the investigation was ongoing regarding the case against LPN #666.Review of the facility policy titled Abuse, Neglect, Exploration, and Misappropriation of Resident's Property and Injuries of Unknown Sources undated revealed misappropriation of resident property meant the deliberate misplacement, exploitation or wrongful, temporarily or permanent, use of a resident's belongings or money without the resident's consent.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and facility policy review the facility failed to ensure the Minimum Data Set (MDS) was accurately coded. This affected four residents (#25, #31, #36 and #15) and had the potential to affect 13 residents the facility identified as receiving respiratory services at the facility. The facility census was 82.Findings included:1 - Review of Resident #25 revealed an admission date of 08/02/24. Diagnosis included chronic kidney disease, obstructive sleep apnea, chronic obstructive pulmonary disease, and obesity. Review of Resident #25's quarterly Minimum Data Set (MDS) dated [DATE] revealed she had an intact cognition. The resident was coded as requiring invasive mechanical ventilation. Review of Resident #25's medical record revealed a physician's order dated 12/04/25 for ventilator/volume targeted pressure support. VT-325 PEEP minute-5 PEEP max-15 PS max-15 auto I Time=auto rise-3. Oxygen (O2) may titrate to maintain saturation greater than or equal to 90% nightly and during naps. May titrate settings for patient comfort/tolerance every shift for ventilator dependence. Daily use required. Observation on 03/31/26 at 3:10 P.M. revealed Resident #25 was in his wheelchair in the hallway free of invasive mechanical ventilation. 2 – Review of Resident #31's medical record revealed an admission date of 08/04/20. Diagnosis included chronic obstructive sleep apnea and dependence on a respirator status. Review of Resident #31's annual MDS dated [DATE] revealed the resident had an intact cognition. The resident was coded as requiring an invasive mechanical ventilator. Review of Resident #25's medical record revealed a physician's order dated 12/04/25 for ventilator/volume targeted pressure support. VT-325 PEEP minute-5 PEEP max-15 PS max-15 auto I Time=auto rise-3. O2 may titrate to maintain saturation greater than or equal to 90% nightly and during naps. May titrate settings for patient comfort/tolerance every shift for ventilator dependence. Daily use required. Observation of Resident #25 on 04/01/26 at 7:52 A.M. revealed the resident was free of invasive mechanical ventilation. 3 – Review of Resident #36's medical record revealed an admission date of 06/23/20. Diagnosis included chronic obstructive pulmonary disease, dependence on respirator ventilator status, and acute respiratory failure with hypoxia. Review of annual Resident #36 annual MDS dated [DATE] revealed the resident was coded as requiring an invasive mechanical ventilator. Review of Resident #36's medical record revealed a physician's order dated 12/04/25 for ventilator/volume targeted pressure support. VT-325 PEEP minute-5 PEEP max-15 PS max-15 auto I Time=auto rise-3. O2 may titrate to maintain saturation greater than or equal to 90% nightly and during naps. May titrate settings for patient comfort/tolerance every shift for ventilator dependence. Daily use required. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Observation of Resident #36 on 04/01/26 at 8:04 A.M. revealed the resident was free of invasive mechanical ventilation. Interview with the Ohio Department of Health Resident Assessment Instrument (RAI) and (outcome and Assessment Information set (OASIS) Education Coordinator on 03/31/26 revealed the average volume-assured pressure support (AVAPS) is a non-invasive ventilation that integrates the characteristics of both volume and pressure-controlled non-invasive ventilation. AVAPS is most closely aligned with BiPAP and should be coded at O0110G2, BiPAP when used during the look-back period. A National Institute of Health StatPearls available at https://www.ncbi.nlm.nih.gov/books/NBK560600/ addresses 'Average Volume-Assured Pressure Support.' That article states, Different modalities of non-invasive ventilation exist, with continuous positive airway pressure (CPAP) and bilevel positive airway pressure (BiPAP) being the most commonly used modes. Interview with the MDS Nurse #251 on 03/31/26 at 11:05 A.M. verified Resident #25, #31, and #36's MDS was coded as receiving an invasive mechanical ventilator because the MDS manual directed him to do so. Review of the RAI manual coding instructions for Invasive Mechanical ventilator (ventilator or respirator) revealed: Code any type of electrically or pneumatically powered closed-system mechanical ventilator support device that ensures adequate ventilation in the resident who is or who may become (such as during weaning attempts) unable to support their own respiration in this item. During invasive mechanical ventilation the resident's breathing is controlled by the ventilator. Residents receiving closed-system ventilation include those residents receiving ventilation via an endotracheal tube (e.g., nasally or orally intubated) or tracheostomy. A resident who has been weaned off of a respirator or ventilator in the last 14 days or is currently being weaned off a respirator or ventilator, should also be coded here. Do not code this item when the ventilator or respirator is used only as a substitute for BiPAP or CPAP. Review of the facility policy titled Resident Assessment revised 2019 revealed all persons who have completed any portion of the MDS Resident Assessment Form must sign the document attesting to the accuracy of such information. 4 - Review of Resident #15's medical record revealed an admission date of 11/14/24. Diagnoses included acute respiratory failure with hypoxia, Chronic Obstructive Pulmonary Disease (COPD), heart failure, hypertension, Type Two Diabetes Mellitus, and generalized anxiety disorder. Review of Resident #15's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 had severely impaired cognition with a Brief Interview for Mental Status (BIMS) score of seven. Further review of the MDS assessment revealed Resident #15 did not require the use of oxygen therapy. Review of Resident #15's care plans dated 03/26/26, 01/02/26, 10/09/25, and 09/29/25 revealed oxygen therapy was not included in the care plan. Review of Resident #15's physician orders dated 03/23/26 revealed no order for oxygen administration. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of Resident #15's progress notes dated 03/25/25, 05/06/25, 05/07/25, 05/10/25, 05/19/25, 05/21/25, 06/13/25, 07/06/25, and 03/28/26 revealed Resident #15 was receiving oxygen via nasal canula. Interview on 03/30/26 at 10:38 A.M. with LPN #303 verified Resident #15 was receiving oxygen at two liters per minute (lpm) via nasal canula. LPN #303 verified Resident #15 did not have an order for oxygen. LPN #303 stated she thought Resident #15's oxygen order was as needed for shortness of breath and she stated Resident #15 had always worn oxygen. Interview on 03/31/26 at 10:22 A.M. with the Director of Nursing (DON) verified Resident #15 had been receiving oxygen therapy since 03/25/25 and had no physician order for oxygen therapy. Furthermore, the DON verified oxygen administration was not included in Resident #15's care plan and the MDS assessment was inaccurate as Resident #15 had received oxygen since 03/25/25. Review of the facility policy with a last revised date of November 2019 titled Resident Assessments revealed a comprehensive assessment of every resident's needs is made at intervals designated by Omnibus Budget Reconciliation Act of 1987 (OBRA) and Prospective Payment System (PPS) requirements. Furthermore, all persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information. This deficiency represents non-compliance investigated under Complaint Number 2678071.

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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 medical record review, observation, staff interview, family interview, and policy review, the facility failed to ensure Activities of Daily Living (ADL) care was provided for dependent residents. This affected two residents, (#54 and #63) of three residents reviewed for ADL care. The facility census was 82. Findings include: 1.Review of Resident #63's medical record revealed an admission date of 08/12/24. Diagnoses included hypertensive chronic kidney disease, hypertension, dementia without behavioral disturbance, muscle weakness, and aortic ectasia. Review of Resident #63's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #63 required supervision or touching assistance for personal hygiene and partial or moderate assistance for showering and bathing. Review of Resident #63's care plan dated 01/14/26 revealed Resident #63 had a self-care deficit related to weakness and cognitive impairment with interventions that included for staff to assist with ADL's as needed and to report improvement or decline in Resident #63's participation with ADL's. Interview on 04/01/26 at 9:05 A.M. with Resident #63's Medical Power of Attorney (POA) revealed Resident #63 had not had her hair or teeth brushed that morning before leaving her bedroom for breakfast. Observation on 04/01/26 at 9:12 A.M. of Resident #63 sitting at the dining table revealed Resident #63's hair to be disheveled. Interview on 04/01/26 at 9:14 A.M. with Certified Nursing Assistant (CNA) #315 verified she had not brushed Resident #63's hair or teeth during morning personal hygiene care. 2. Review of the medical record for Resident #54 revealed an admission on [DATE]. Diagnoses included unspecified dementia, major depressive disorder, chronic kidney disease. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #54 was cognitively impaired. Further review of the MDS revealed Resident #54 required supervision or touching assistance with Activities of Daily Living (ADLs). Review of the care plan dated 01/14/26 revealed Resident #54 had an ADL self care deficit related to disease process. Interventions included assisting with ADL as needed. Report improvement or decline in resident participation with ADLs. Observation on 03/30/26 at 10:39 A.M. revealed Resident #54 sitting at the dining room table with hair sticking out on the right side, appearing unkept. Observation on 04/01/26 at 9:36 A.M. revealed Resident #54 sitting at the dining room table with hair sticking out on the right side, appearing unkept. Interview on 04/01/26 at 9:26 A.M. with Certified Nursing Assistant (CNA) #307 revealed CNA #307 was not sure who was to take care of Resident #54. CNA #307 verified Resident #54's hair was (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unbrushed, and her morning care was not complete. CNA #307 stated there were two CNA's on the dementia unit and then stated Resident #54 was actually on her assignment for the day. CNA #307 further confirmed that Resident #54 requires assistance with Activities of Daily Living (ADLs). Review of the facility policy titled Activities of Daily Living (ADLs), Supporting dated 03/2024, revealed appropriate care and services will be provided for residents who are unable to carry out ADLs independently. This deficiency represents non-compliance investigated under Complaint Number 2678071.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide activities to meet all resident's needs. Based on observations, staff interview, and policy review, the facility failed to provide activities to meet the residents' needs and cognitive capabilities. This affected 24 residents who reside in the memory care unit. The facility census was 82.Findings include:Observation of the memory care unit activities calendar for March 2026 revealed the week of 03/01/26 the facility had juice and news, and table talk everyday of the week. The facility had one day a week on Wednesdays where the residents did an activity called morning stretch.Observation on 03/31/26 at 10:00 A.M. of the memory care unit revealed five residents sitting around the dining room table. There was nothing provided for the residents besides music on the television.Observation on 04/01/26 at 9:06 A.M. revealed seven residents sitting in the dining room, with only music playing on the television. Additional observation on 04/01/26 at 9:27 A.M. revealed Activity Aide #247 distributing word searches to the residents sitting around the dining room table. Resident #9, Resident #59, and Resident #32 were sitting in recliner chairs in front of the television. Activity Aide (AA) #247 did not offer the residents in the recliners an activity.Interview on 04/01/26 at 9:10 A.M. with Certified Nursing Assistant (CNA) #315 revealed she was from agency but frequently picked up at the facility in the memory care unit. CNA #315 stated there were no activities for the residents and confirmed that residents were not offered any type of mental stimulation between scheduled activities.Interview on 04/01/26 at 9:35 A.M. with AA #247 revealed Resident #9 was blind, so AA #247 did not offer activities to Resident #9 but would let her sit next to her during the activity. AA #247 confirmed Resident #9 should be offered an alternative activity to accommodate her needs. AA #247 stated Resident #59 wanders and exit seeks, therefore if Resident #59 is sitting when no activity is offered. AA #247 further stated that she did not know what Resident #32's name was but knew that he liked to wander and gets agitated easily and confirmed he was not offered an activity.Review of the facility policy titled Memory Care Unit Activity Programming not dated, revealed Activity Programming on the Memory Care Unit will offer a diverse variety of events throughout the day, including both structured and spontaneous options as the residents prefer. Activities will be adapted and modified based on resident abilities day to day and with the progression of their dementia.This deficiency represents non-compliance investigated under Complaint Number 2678071 and Complaint Number 2677052.

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Bethesda Care Center	600 N Brush St Fremont, OH 43420

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews, review of an Emergency Medical Service (EMS) run report, staff and resident interviews, and review of facility policies, the facility failed to ensure follow up care was provided when skin breakdown was noted, failed to document skilled assessments, vital signs, and failed to notify the physician regarding a change of condition. The facility also failed to implement physician orders following an office visit. This affected two (Residents #77 and #91) of two residents reviewed for quality of care. The facility census was 82.Findings include:1.Review of the closed medical record for Resident #91revealed an admission on [DATE] and a discharge date of [DATE]. Diagnoses included Parkinsons Disease, essential hypertension, and dorsalgia. Further review of the medical record revealed no care plan or Minimum Data Set (MDS) had been completed due to time of admission and discharge. Review of the nurse progress notes revealed Resident #91 arrived at the facility on [DATE] from the hospital with a diagnosis of weakness. Review of the admission and readmission packet dated [DATE] revealed Resident #91's blood pressure was 145/82, pulse was 68, and temperature was 97.6. Resident #91 was alert to person, place and time. Review of the vital signs for Resident #91 revealed a blood pressure was last obtained on [DATE] at 8:01 P.M. of 148/75, a pulse oximetry of 98 percent (%) on two liters of oxygen via nasal cannula, pulse of 80, respiratory rate of 20, and temperature of 97.5 degrees Fahrenheit (F). There were no further vitals obtained throughout Resident #91's stay at the facility. Review of the physician's orders revealed no order for oxygen. Review of the nurse progress note dated [DATE] revealed a late entry for skilled documentation on [DATE] at 6:31 A.M. There were no vitals obtained. Skilled documentation charting for [DATE] at 6:36 A.M. revealed no vitals were obtained. Skilled documentation and assessment were not charted on [DATE], [DATE], and [DATE]. Review of the physician progress note dated [DATE] revealed Resident #91 was admitted to the facility on [DATE]. Resident #91 had a history of thoracic spine fracture and was being seen for significant muscle spasms and pain in the lower back and hips. Additional review of the physician progress note revealed the physician used the vital signs from [DATE]. Review of the Occupational Therapy Treatment Encounter Notes dated [DATE] revealed Resident #91's response to treatment was, Resident #91 had decreased alertness and lethargy during evaluation. Resident #91 was constantly falling asleep and required verbal cues to stay awake. Review of the physician's orders revealed an order on [DATE] for before and after nebulizer and incentive spirometry treatment, check the following, lung sounds, pulse rate, and pulse oximetry. Document the number of minutes for set up and cleanup of equipment, every shift document total time it takes for set up, assessment, and monitoring. Review of the Treatment Administration Record for Resident #91 revealed on [DATE] through (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] the staff documented fifteen minutes of set up time, but there was no documentation of lung sounds, pulse rate, or pulse oximetry. Review of the nurse progress notes dated [DATE] at 2:36 A.M. revealed a urine was obtained as ordered for a urinalysis by straight catheterization without incident. Resident #91's urine was dark in color and odorous. Licensed Practical Nurse (LPN) #311 noted an open area on right abdominal fold and groin area to outer right hip. Both noted areas were cleaned with soap and water and patted dry. LPN #311 applied Peri-Protect to right abdominal fold and groin area, and Resident #91's brief was left open. LPN #311 stated the Nurse Practitioner was notified. LPN #311 also noted an approximately two centimeters by two centimeter raised area to Resident #91's left outer labia. Review of the TAR from [DATE] through [DATE] revealed no monitoring of skin, or open areas to the right abdominal fold and groin area. There was no monitoring of the raised area to Resident #91's left outer labia. Review of the nurse progress notes dated [DATE] at 5:27 A.M. revealed Resident #91's Cyclobenzaprine (muscle relaxer)10 milligram (mg) tablet was held due to Resident #91 being lethargic. LPN #311 was unable to keep Resident #91 awake for a conversation. There was no notification to the physician documented. Review of the nurse progress notes dated [DATE] at 1:54 P.M. revealed LPN #666 administered morning medication to Resident #91. Upon vital assessment LPN #666 had concerns for Resident #91. LPN #666 was alerted by aides that Resident #91 was breathing different. LPN #666 returned to Resident #91's room to find Resident #91 unresponsive. Full code was initiated per advanced directives. LPN #666 called for crash cart, 911, to be called. LPN #666 and another nurse continued Cardiopulmonary Resuscitation (CPR) until Emergency Medical Services (EMS) arrived. EMS called time of death on [DATE] at 10:15 A.M. Review of the Medication Administration Record (MAR) revealed on [DATE] morning medications were administered at 8:56 A.M. There were no vital signs documented. Review of the EMS run report revealed EMS arrived at the facility at 9:47 A.M. for a verbally unresponsive female. Per nurse Resident #91 presented with lethargy and hypotension the morning of [DATE] and medications were withheld due to this. Interview on [DATE] at 1:54 P.M. with Resident #91's family revealed on [DATE], Resident #91's family had attempted to contact Resident #91 multiple times without success. The family was able to get a nurse to answer Resident #91's cell phone and Resident #91 stated that something was not right, and she was going to be sent to the emergency room. Resident #91's family stated they did not hear from the facility until after Resident #91 had been pronounced dead. Resident #91's family stated before arriving at the facility Resident #91 was alert and was receiving therapy at the facility. Resident #91's family stated a nurse informed them the morning that Resident #91 had passed she had not voided all night. Resident #91's family could not remember the time they spoke to Resident #91. Resident #91's family stated that during a visit on [DATE] Resident #91 was hallucinating and it was reported to the nurse, but the family was never notified what the physician had said. Interview on [DATE] with Director of Nursing (DON) at 7:27 A.M. confirmed that Resident #91 was a skilled resident and should have had a skilled assessment twice daily containing vital signs. DON further confirmed that Resident #91 had no vitals obtained from [DATE] through [DATE]. DON (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed staff was not monitoring Resident #91's open area to the abdomen and groin, and there was no follow-up documented regarding the raised area to Resident #91's labia. DON confirmed it was documented that Resident #91 was wearing oxygen and further confirmed Resident #91 did not have an order for oxygen. DON also confirmed that staff should have been documenting lung sounds, pulse and pulse oximetry twice a day as ordered for use of incentive spirometry as documented. Interview on [DATE] at 11:13 A.M. with LPN #311 revealed Resident #91did not receive the Cyclobenzaprine 10mg because she was difficult to arouse. LPN #311 stated it must not have been concerning if she did not notify the physician. LPN #311 further stated the charting pertaining to the abdominal fold, groin and labia notification was written in a book and the nurse practitioner was not verbally notified or faxed. Interview on [DATE] at 11:30 A.M. with Certified Nursing Assistant (CNA) #229 revealed on the morning of [DATE] Resident #91 refused to get out of bed which was not normal for her. CNA #229 stated she reported her findings to LPN #666. Interview on [DATE] at 11:40 A.M. with Medical Director (MD) #313 revealed staff should notify the physician or on call Nurse Practitioner (NP) any time there is a change in condition with a resident. MD #313 confirmed if Resident #91 received medication at 8:56 A.M. on [DATE]. 2. Review of the medical record for Resident #77 revealed she was admitted on [DATE] with diagnoses including diverticulosis, anemia, obstructive sleep apnea, atrial fibrillation, sick sinus syndrome, and unspecified hemorrhoids. Review of the quarterly Minimum Data Set 3.0 (MDS) assessment dated [DATE] for Resident #77 revealed she was cognitively intact, did not display behaviors toward others, and did display refusals of care at the time of this assessment. She utilized a walker with supervision and a wheelchair independently, required minimal to moderate assistance with activities of daily living, and was independent with bed mobility and transfers. Review of gynecology visit notes and orders dated [DATE] revealed Resident #77 was diagnosed with a labial cyst, and sitz bath treatments were ordered. Review of a facility physician progress note dated [DATE] for Resident #77 revealed a labial cyst was being managed by gynecology with recommendations to continue sitz bath treatments as ordered. Review of the physician orders and care plan for Resident #77 revealed no documented orders nor care plan interventions for sitz bath treatments for management of the labial cyst. Interview on [DATE] at 6:46 A.M. with Resident #77 revealed the facility did not have the necessary equipment to perform sitz baths. She stated her first sitz bath occurred on [DATE] after her representative provided a sitz bath basin and Epsom salt. Resident #77 reported improved comfort following initiation of treatments. Interview on [DATE] at 11:10 A.M. with Licensed Practical Nurse #202 confirmed Resident #77 began sitz baths during the week of [DATE]. Interview on [DATE] at 12:44 P.M. with the Assistant Director of Nursing #252 confirmed the sitz (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bath treatments ordered on [DATE] for Resident #77 were not implemented in a timely manner. Interview on [DATE] at 12:46 P.M. with Resident #77's representative revealed the facility was verbally notified by him of the sitz bath order upon return from the gynecology appointment on [DATE], in addition to receiving written provider orders. The representative stated the facility did not provide the treatments due to lack of equipment, and he obtained the necessary supplies during the week of [DATE]. Review of facility policy titled Charting and Documentation, dated [DATE], revealed the facility ensured resident medical records facilitated communication between the interdisciplinary team regarding resident condition and response to care. Review of facility policy titled Medication and Treatment Orders, dated [DATE], revealed treatment orders would be implemented consistent with principles of safe and effective order writing. This deficiency represents non-compliance investigated under Complaint Numbers 2702693, 2678071, and 2650249.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, staff interview, and policy review, the facility failed to ensure hazardous chemicals and medications were properly stored. This had the potential to affect 10 residents (#9, #11, #22, #26, #32, #45, #54, #59, #63, and #73) who the facility identified to be cognitively impaired and independently mobile on the 200 hall. The facility census was 82. Findings include:Observation on 04/01/26 at 9:30 A.M. of the 200 Memory Care (MC) hall revealed the door to the soiled linen room did not require a code to enter the room and the door was unlocked. One Certified Nursing Assistant (CNA) was observed to open the door without entering a code as the door was unlocked.Interview on 04/01/26 at 9:34 A.M. with Business Office Manager (BOM) #212 verified the door to the soiled linen room did not require a code to enter the room and was unlocked. Furthermore, BOM #212 verified inside of the soiled linen room in an unlocked cabinet above the sink contained antifungal powder - miconazole nitrate 2 percent (%), two tubes of antifungal cream - miconazole nitrate 2%, moisture barrier cream 12% zinc oxide and 1% dimethicone, and spill magic all-purpose spill clean-up absorbent powder. All medications and the chemical had a label that stated to keep out of reach of children.Review of the facility policy with a revised date of July 2023 titled Hazardous Areas, Devices, and Equipment revealed all hazardous areas, devices, and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Self-Reported Incident review, medical record review, and staff interview, the facility failed to ensure medications documentation was completed accurately for one (Resident #10). This had the potential to affect 18 residents (#4, #5, #10, #25, #27, #29, #31, #36, #37, #41, #50, #56, #57, #58, #60, #65, #68, #70) the facility identified as receiving opioid medication in the facility. The census was 82. Findings Include:Review of Resident #10's medical record revealed an admission date of 06/21/25. Diagnosis included congestive heart failure, end stage heart failure, Diabetes Mellitus Type II, and chronic obstructive pulmonary disease. Review of Resident #10's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had an intact cognitionReview of Resident #10's most recent care plan revealed she had a potential for alteration in comfort related to the disease process. interventions included educating the resident to request pain medication before her pain became severe.Review of Resident #10's medical record revealed a physician's order dated 09/06/25 for Oxycodone HCl oral tablet five milligrams (mg) to administer two every six hours as needed (PRN) for pain level of six to 10. Review of Resident #10's Medication Administration Record dated September 2025, and October 2025 revealed the resident was administered Oxycodone HCL 5 mg two tablets on 09/09/25 at 8:01 P.M. for a pain level of four, the medication was noted to be effective. On 09/11/25 at 2:03 A.M. the resident was administered Oxycodone HCL 5 mg two tablets for a pain level of eight, the medication was noted to be effective. On 10/02/25 at 9:01 P.M. the resident was administered Oxycodone HCL 5 mg two tablets for a pain level of four, the medication was noted to be effective. Review of Resident #10's Controlled Drug Administration Record revealed Oxycodone HCL 5 mg two tablets were documented as removed from the secured narcotic lock box on the following dates and time for Resident #10; 09/06/25 at 3:00 P.M., 09/07/25 at 7:00 A.M. and 4:00 P.M., 09/10/25 at 8:05 A.M. and 10:40 A.M., 09/11/25 at 2:03 A.M. and 10:00 A.M., 09/12/25 at 7:30 A.M. and 1:00 P.M. Review of the facility completed self-reported incident number 266988 revealed upon review of narcotic documentation, a facility nurse License Practical Nurse (LPN) #666 was found to have signed for a narcotic on the controlled drug administration record, but failed to document administration in the electronic Medication Administration Record (MAR). Review of LPN #666's Disciplinary Action Report dated 11/05/25 revealed the nurse failed to properly document the administration of controlled substances on multiple occasions and shifts. The decision was made fto terminate the employee following repeated failures to properly document the administration of controlled substances, which violates company policy and regulatory standards. Despite prior warnings and guidance, the issue persisted and had compromised the facility compliance and patient safety protocols.Interview with the Administrator and Director of Nursing on 04/01/26 revealed neither were employed by the facility during that time and were unfamiliar with the investigation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, resident and staff interviews, and review of facility policies, the facility failed to ensure personal protective equipment was utilized for residents in contact precautions. This affected one (Resident #85) of one resident reviewed for contact precautions. Additionally, the facility failed to ensure hand hygiene was performed while delivering meal trays to resident rooms. This affected four (Residents #8, #14, #51, and #85) of 13 residents observed for meal tray delivery.Findings include:1. Review of the medical record for Resident #85 revealed she was admitted on [DATE] with diagnoses including Type Two Diabetes Mellitus, direct infection of left ankle and foot, unspecified psychosis, stage three chronic kidney disease, osteoarthritis, skin transplant status, and osteomyelitis.Review of the Minimum Data Set 3.0 assessment dated [DATE] for Resident #85 revealed she was cognitively intact and did not display any behaviors nor refusals of care at the time of this assessment. Resident #85 required moderate assistance with activities of daily living and ambulation. She had a peripherally inserted central catheter and received intravenous antibiotics.Review of the care plan dated 03/22/26 for Resident #85 revealed focus areas related to fall prevention and intravenous antibiotic therapy for a wound infection to her left lower extremity.Review of physician orders for Resident #85 revealed an order dated 03/20/26 for single room isolation with contact precautions every shift.Observation of Resident #85's door to her room revealed personal protective equipment (PPE) and a contact isolation sign hanging on the door. The contact isolation sign indicated all visitors and staff were to perform hand hygiene prior to entering the room and all staff were to don gloves and a gown prior to entering the room.Interview on 03/30/26 at 9:17 A.M. with Resident #85 revealed staff were not donning the required PPE for contact precautions prior to entering her room.Observation on 03/30/26 at 8:00 A.M. of Certified Nurse Assistant #309 revealed she delivered a breakfast tray to Resident #85's room, set the tray on her bedside table next to the bed, and did not perform hand hygiene nor don the required PPE for contact precautions prior to entering the room.Interview on 03/30/26 at 8:15 A.M. with CNA #309 confirmed she did not perform hand hygiene nor don the required PPE prior to delivering Resident #85's breakfast tray to her bedside table located inside the room next to the bed.Observation on 03/30/26 at 9:45 A.M. of Social Services Assistant (SSA) #220 revealed she entered Resident #85's room and did not perform hand hygiene nor don the appropriate PPE for contact precautions.Interview on 03/30/26 at 9:51 A.M. with SSA #220 confirmed she did not perform hand hygiene nor don the required PPE as required for contact precautions prior to entering Resident #85's room to assist with her needs.Observation on 03/30/26 at 1:33 P.M. of Licensed Practical Nurse (LPN) #202 revealed she was sitting on Resident #85's bed, accessing the resident's peripherally inserted central catheter (PICC), and was not wearing a gown as required for contact precautions.Interview on 03/30/26 at 1:39 P.M. with LPN #202 confirmed she did not don a gown as required for contact precautions prior to entering Resident #85's room to provide care involving the resident's PICC line.Review of in-service documentation revealed LPN #202 had been trained on contact precautions, including the necessary PPE and how to use it, on 12/04/25.Review of in-service documentation with the Director of Nursing revealed CNA #309 had been trained on hand hygiene and contact precautions, including the necessary PPE and how to use in, on 12/01/25. Review of facility policy titled Isolation - Categories of Transmission-Based Precautions, dated October 2018, revealed visitors and staff would don gloves and a gown prior to entering the room of a resident in contact precautions.2. Review of the medical record for Resident #8 revealed he was admitted on [DATE] with diagnoses including heart failure, chronic obstructive pulmonary disease, Parkinson's disease, Lewy body dementia, diverticulosis, venous insufficiency, and Type Two Diabetes Mellitus.Review of the medical record for Resident #14 revealed she was admitted on [DATE] with diagnoses including disease of the pancreas, pulmonary nodule, jaundice, diaphragmatic hernia, arteriovenous malformation, and unspecified intra-abdominal (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and pelvic swelling with a mass and lump.Review of the medical record for Resident #51 revealed she was admitted on [DATE] with diagnoses including pyloric stenosis, intestinal obstruction, hypovolemia, ulcerative colitis, malignant neoplasm of rectum, and protein-calorie malnutrition.Review of the medical record for Resident #85 revealed she was admitted on [DATE] with diagnoses including Type Two Diabetes Mellitus, direct infection of left ankle and foot, unspecified psychosis, stage three chronic kidney disease, osteoarthritis, skin transplant status, and osteomyelitis.Observation on 03/30/26 at 8:00 A.M. of Certified Nurse Assistant (CNA) #309 revealed she delivered breakfast trays to Residents #8, #14, #51, and #85 who was in contact precautions, and did not perform hand hygiene between deliveries. She touched the bedside tables in each of the rooms. While in Resident #14's room she touched the resident. While in Resident #51's room she touched a water cup and personal belongings on the bedside table.Interview on 03/30/26 at 8:15 A.M. with CNA #309 confirmed she did not perform hand hygiene while passing breakfast trays to Residents #8, #14, #51, and #85.Review of in-service documentation with the Director of Nursing revealed CNA #309 had been trained on hand hygiene on 12/01/25. Review of facility policy titled Handwashing/Hand Hygiene, dated August 2024, revealed facility staff would perform hand hygiene before and after direct contact with residents and after contact with objects in the immediate vicinity of residents.This deficiency represents non-compliance investigated under Complaint Numbers 2702693 and 2697818.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of facility policy, the facility failed to provide a comfortable and homelike environment for residents on Memory Care (MC) unit. This had the potential to affect all 24 residents who reside on the MC unit. The facility census was 82. Findings Include: Observation of the MC unit on 03/30/26 at 12:06 P.M. revealed the wall carpet was peeling and unsightly, wallpaper between resident rooms [ROOM NUMBERS] was peeling, two air vents near the nurse's station were visibly soiled, and a ceiling tile near the nurse's station was missing. Interview on 03/30/26 at 12:07 P.M. with Licensed Practical Nurse (LPN) #230 confirmed the wall carpet and wallpaper were peeling and unsightly. Interview on 03/30/26 at 12:08 P.M. with Registered Nurse (RN) #270 confirmed the air vents were dirty and the ceiling tile was missing. RN #270 further stated the ceiling tile had not been replaced following recent remodeling in the MC unit. Observation on 03/31/26 at 12:35 P.M. revealed peeling paint at the nurse's station. Interview on 03/31/26 at 12:36 P.M. with LPN #310 confirmed the paint at the nurse's station was peeling. Observation on 04/01/26 at 1:00 P.M. revealed three lights in the MC dining/common area were flickering and partially illuminated. Interview on 04/01/26 at 1:02 P.M. with LPN #301 and Receptionist #170 confirmed the lights were flickering and not fully functioning. Review of the facility policy titled Quality of Life - Homelike Environment, dated May 2017, indicated the facility is to provide a clean, orderly, and well-maintained environment with adequate lighting and homelike characteristics. This deficiency represents non-compliance investigated under Complaint Number 2677052.