STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365532	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ayden Healthcare of Greenville	243 Marion Drive Greenville, OH 45331

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and staff and resident interview, the facility failed to ensure resident bed linens were clean. This affected one (#29) out of 19 residents reviewed. The facility census was 65.Findings include: Observation on 12/01/25 at 9:59 A.M. revealed Resident #29's bed was made with sides and end of the bed tucked under mattress. The top white blanket had a large oblong light brown stain approximately 12 inches by six inches with a second light brown oblong stain four inches below approximately six inches by four inches The two stains near the top of the blanket. Interview on 12/01/25 at 9:59 A.M. revealed Resident #29 does not know what the stain was from and does not want to have a stained or dirty bed. Interview on 12/01/24 at 10:02 A.M with certified nursing assistant (CNA) #103 verified the bed was made and there were stains on the blanket and STNA #103 would change out the bedding.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of the facility incident log, staff interview, and policy review, the facility failed to follow the abuse policy related to an injury of unknown origin. This affected one resident (#78) of five residents reviewed. The facility census was 65.Based on medical record review, review of the facility incident log, review of the witness statements, staff interview, and policy review, the facility failed to follow the abuse policy related to an injury of unknown origin. This affected one resident (#78) of five residents reviewed. The facility census was 65.Findings include:Review of the medical record for Resident #78 revealed an admission date of 04/09/24 with diagnoses including chronic obstructive pulmonary disease, type two diabetes mellitus, and hypertension.Review of the discharge Minimum Data Set (MDS) dated [DATE] revealed Resident #78 was dependent on staff for all activities of daily living (ADL).Review of the facility incident log revealed Resident #78 had an incident on 08/08/25 at 7:30 AM. Review of the incident report revealed during morning care, the Certified Nursing Assistant (CNA) staff alerted nursing that Resident #78 had a small amount of blood on her pillow and a knot on the side of her head. Resident #78 was unable to voice a description of what happened.Review of the progress note dated 08/08/25 at 11:43 A.M. per the Assistant Director of Nursing (ADON) #120 revealed during morning care, the CNA staff alerted nursing that resident #78 had a small amount of blood on her pillow and a knot on the side of her head.Interview on 12/04/25 at 9:52 A.M. with the Director of Nursing (DON) revealed she was notified of the incident involving Resident #78 on 08/08/25 during her morning rounds. The DON revealed upon entering Resident #78's room she observed Resident #78 in bed with a small hematoma on the side of her head with small amounts of red drainage. The DON revealed she asked CNA #145 and CNA #179 what occurred but neither CNA was able to provide details at the time.Review of the witness statement dated 08/08/25 CNA #145 revealed she provided care for Resident #78 and when she turned the light on, she observed a little dried blood on her pillow. CNA #145 reported that she asked CNA #179 for assistance with transferring Resident #78 from the bed to her wheelchair using a mechanical lift, CNA #145 showed CNA #179 the bump on Resident #78's head, then notified the nurse. CNA #145 and CNA #179 transferred Resident #78 with the mechanical lift to her wheelchair and CNA #145 brought Resident #78 to the hallway where the DON took over.Review of the witness statement dated 08/16/25 CNA #179 revealed when she went to Resident #78's room to assist CNA #145 with transferring the resident, CNA #145 had already found the hematoma on the resident's head. CNA #179 further revealed she then assisted CNA #145 with transferring Resident #78 from the bed to her wheelchair by operating a mechanical lift.Interview on 12/04/25 at 11:33 AM with CNA #179 revealed she observed the hematoma on Resident #78's head after entering the room to assist CNA #145 transferring with the mechanical lift. CNA #179 revealed she had not assisted CNA #145 transfer Resident #78, she believed Licensed Practical Nurse (LPN) #127 assisted her with care and transferring that morning.Interview on 12/04/25 at 11:51 AM with LPN #127 revealed she was the nurse assigned to care for Resident #78 on 08/08/25. LPN #127 denies assisting any CNAs with transferring the resident on that day. LPN #127 further revealed she was notified that Resident #78 had a bump on her head and blood on her pillow, but she did not immediately assess the resident because the DON was handling the incident.Review of the facility policy titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property, revised 10/2024, revealed staff should report all incidents/allegations immediately to the Administrator or designee. If an injury is observed/suspected, staff should not move the resident until he/she has been assessed by a nurse supervisor for possible injuries. A nurse should perform an initial assessment of the resident. Additionally, documentation in the nurses' notes should include the results of the resident's assessment, notification of the physician and the Resident Representative, and any treatment provided. Additionally, an injury is classified as an injury of Unknown Source when all the following conditions are met: 1. The source of the injury was not observed by any person; AND 2. The source of the injury could not be explained by the resident; AND 3. The injury is suspicious because of the extent of the injury, the location of the injury, the number of injuries observed at one particular point in time, or the incidence of injuries over time. Additionally, all incidents and allegations of abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and all injuries of unknown source must be reported immediately to the Administrator or designee.This deficiency represents non-compliance investigated under Complaint Number 2603410.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, facility incident log, staff interview, and facility policy review, the facility failed to report an injury of unknown origin to the state surveying agency. This affected one resident (#78) of five residents reviewed. The facility census was 65.Based on medical record review, review of the facility incident log, staff interview, and policy review, the facility failed to report an injury of unknown origin to the state surveying agency. This affected one resident (#78) of five residents reviewed. The facility census was 65.Findings include:Review of the medical record for Resident #78 revealed an admission date of 04/09/24 with diagnoses including chronic obstructive pulmonary disease, type two diabetes mellitus, and hypertension. Review of the discharge Minimum Data Set (MDS) dated [DATE], Resident #78 was dependent on staff for all activities of daily living (ADLs).Review of the facility incident log revealed Resident #78 had a hematoma incident on 08/08/25 at 7:30 AM. Review of the incident report revealed during morning care, Certified Nurse Assistant (CNA) staff alerted nursing that Resident #78 had a small amount of blood on her pillow and a knot on the side of her head. Resident #78 was unable to voice a description of what happened.Interview on 12/04/25 at 8:19 AM with the Director of Nursing confirmed the facility did not report the incident to the State Surveying Agency.Review of the facility policy titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property, revised 10/2024 revealed an injury is classified as an Injury of Unknown Source when all the following conditions are met: 1. The source of the injury was not observed by any person; AND 2. The source of the injury could not be explained by the resident; AND 3. The injury is suspicious because of the extent of the injury, the location of the injury, the number of injuries observed at one particular point in time, or the incidence of injuries over time. Additionally, all incidents and allegations of abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and all injuries of unknown source must be reported immediately to the Administrator or designee. If any form of abuse is alleged or serious bodily injury is identified related to any other reportable incident (e.g., Injury of Unknown Source or allegation of Neglect involving serious bodily injury,) the Administrator or his/her designee will notified Ohio Department of Health (ODH) immediately, but not later than two (2) hours after the allegation is made or the serious bodily injury identified. This deficiency represents non-compliance investigated under Complaint Number 2603410.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, review of the facility's incident investigation, and policy review, the facility failed to complete a thorough investigation into a resident's injury of unknown source when the resident obtained a hematoma with bleeding to her head. This affected one (Resident #78) of five residents reviewed for abuse, misappropriation, neglect, and injury of unknown origin. The facility census was 65. Findings include:Review of the medical record for Resident #78 revealed an admission date of 04/09/24 with diagnoses including chronic obstructive pulmonary disease, and type two diabetes mellitus. Review of the discharge Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #78 was dependent on staff for all activities of daily living (ADLs). Review of the nursing progress notes dated 08/08/25 written by Assistant Director of Nursing (ADON) #120 revealed during morning care, Certified Nursing Assistant (CNA) staff alerted nursing that Resident #78 had a small amount of blood on her pillow and a knot on the side of her head. The interdisciplinary team (IDT) considered that the bar from the Hoyer lift struck the resident on the side of the head during transfer into bed. Review of the facility incident log revealed Resident #78 had a hematoma incident on 08/08/25 at 7:30 AM. During morning care, CNA staff alerted nursing that Resident #78 had a small amount of blood on her pillow and a knot on the side of her head. Resident #78 was unable to voice a description of what happened. Review of CNA #145's witness statement dated 08/08/25 revealed she changed and dressed her lower extremities. Then turned on the light and noticed little dried and red blood on her pillow. After noting the blood, she saw CNA #179 in the hallway and they looked at the bump together and told the nurse. Then CNAs #179 and CNA #145 transferred Resident #78 by Hoyer to her chair. Review of Licensed Practical Nurse (LPN) #156's statement dated 08/08/25 revealed Resident #78 rested well through the night and at 5:23 A.M., LPN #156 administered her scheduled lorazepam (treats anxiety). Resident #78 opened her eyes and mouth and took the medications without problems. No signs or symptoms of distress. Review of CNA #179's witness statement dated 08/16/25 revealed when she went to Resident #78's room to assist CNA #145 with transferring the resident, CNA #145 had already found the hematoma on the resident's head. CNA #179 further revealed she then assisted CNA #145 with transferring Resident #78 from the bed to her wheelchair by operating a Hoyer lift. CNA #179 verified the date of her statement was correct during an interview on 12/04/25 at 11:33 A.M. Review of undated statement by CNA #140 revealed on 08/07/25, CNA 140# waited until Resident #78's husband left to put Resident #78 back to bed. Resident #78 was a two-persons assist to transfer to bed. CNA #105 and herself put in bed at 9:30 P.M. There was nothing wrong with Resident #78 at this time, completed two hours checks throughout the night. At 6:00 A.M., no blood was seen on pillow or resident. The facility's investigation was not completed timely. The facility did not complete a thorough investigation to determine what caused the injury of unknown origin. The incident investigation for Resident #78 revealed staff provided inconsistent accounts regarding when the resident's scalp hematoma was first identified, who was present during transfers, and whether the required two-person assistance was provided. The resident required mechanical lift transfers; however, staff were unable to consistently confirm they followed established procedures for safe transfer and supervision. The facility determined the Hoyer bar was what caused the injury prior to having all staff statements. There was no witness statement from CNA #105 who assisted with the transfer on 08/07/25 at 9:30 P.M. and the IDT considered the injury occurred when being transferred into bed. The investigation did not show if the Hoyer lift was already in the room when CNA #179 entered the room, where it was placed when CNA #179 entered the room, and if the Hoyer had any blood on it and/or any blood noted elsewhere to indicate how the injury of unknown was obtained. There was no statement from Resident #78's husband to determine if he saw any injuries on Resident #78's forehead when he left at 9:30 P.M. on 08/07/25. Interview on 12/04/25 at 9:52 AM with the Director of Nursing (DON) revealed she was notified of the incident involving Resident #78 on 08/08/25 during her morning rounds. The DON revealed upon entering Resident #78's room, she observed Resident #78 in bed with a small hematoma on the side of her head with small amounts of red drainage. The DON revealed she asked CNA #145 and CNA #179 what occurred but neither CNA was able to provide details at that time. The DON revealed she investigated the incident and had initially thought CNA #145 must have transferred Resident #78 with the Hoyer by herself. Interview on 12/04/25 at 11:33 A.M. with CNA #179 revealed she observed the hematoma on Resident #78's head after entering the room to assist CNA #145 transferring with the Hoyer lift. CNA #179 revealed she did not assist CNA #145 transfer Resident #78, she

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to ensure a resident care plan addressed their dental needs. This affected one (Resident #55) out of 19 residents reviewed for care planning. The facility census was 65.Findings Include:Review of the medical record revealed Resident #55 was admitted to the facility on [DATE]. Diagnoses included Parkinson's disease without dyskinesia, mild protein calorie malnutrition, human immunodeficiency virus disease, type two diabetes mellitus, and adult physical abuse. Review of Resident #55's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was moderately cognitively impaired and required supervision with eating. Resident #55 was dependent with oral hygiene, toileting, showering, upper body dressing, lower body dressing, putting on and taking off footwear, personal hygiene, rolling left and right, sitting to lying, lying to sitting, sitting to standing, chair transfers, toilet transfers, and tub transfers. Resident #55 was noted with mouth pain, facial pain, discomfort or difficulty with chewing. Review of a progress note dated 10/15/25 at 2:53 P.M. revealed Resident #55 complained of a tooth ache in the right lower jaw line. Hospice was notified and Resident #55 was started on amoxicillin 875/125 milligrams (mgs) give one tablet every 12 hours for a bacterial infection for 10 days. Review of the dental visit dated 11/05/25 revealed Resident #55 was seen by the dentist, and a referral was sent for extractions. Review of the care plan on 12/03/25 revealed Resident #55 did not have a care plan to address his dental needs, mouth pain or need for extractions. Interview with the Administrator on 12/03/2025 at 10:21 A.M. verified Resident #55 needed teeth extractions due to dental pain. The Administrator verified Resident #55 did not have a care plan for his dental needs, mouth pain or need for extractions. Review of the policy titled Care Planning dated August 2021 revealed the care plan was based on the resident's comprehensive assessment and was developed by the interdisciplinary team.

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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. Based on interview, record review, and policy review, the facility failed to provide appropriate oral care. This affected one (Resident #62) of two residents reviewed for dental care. The facility census was 65. Based on medical record review, staff interview, and policy review, the facility failed to provide appropriate oral care. This affected one (#62) of two residents reviewed for dental care. The facility census was 65. Findings Include: Review of the medical record for Resident #62 revealed an admissions date of 03/31/15 with diagnoses including hemiplegia and hemiparesis following cerebral infraction affecting left dominant side and muscle weakness.Review of the Minimum Data Set (MDS) for Resident #62 dated 10/07/25 revealed the resident was cognitively intact and required assistance with activities of daily living. Further review revealed Resident #62 does not exhibit the behavior of rejection of care. Review of the medical record revealed Resident #62 was seen by the dentist on 10/17/25. The notes revealed recommendations for staff to assist the resident with brushing twice daily. Review of the oral care log for Resident #62 revealed that on the following days the resident was offered oral care once 09/02/25, 09/04/25, 09/05/25, 09/07/25, 09/08/25, 09/10/25, 09/13/25, 09/14/25, 09/15/25, 09/23/25, 09/26/25, 09/28/25, 10/01/25, 10/02/25, 10/03/25, 10/07/25, 10/09/25, 10/10/25, 10/12/25, 10/13/25, 10/14/25, 10/17/25, 10/23/25, 10/29/25, 10/30/25, 10/31/25, 10/05/25, 10/10/25, 11/17/25, 11/20/25, and 11/30/25.Interview on 12/01/25 at 9:51 A.M. with Resident #62 verified the resident is unable to brush his teeth without staff assistance. Resident #62 stated that staff do not brush his teeth daily and that it was usually only done on days that he gets his showers. Interview on 12/04/25 at 9:38 A.M. with the Director of Nursing verified that there was not documentation of Resident #62 being offered oral care twice daily on the above dates. Review of the facility policy titled, Activities of Daily Living (ADL), Supporting dated August 2021, revealed appropriate care and services will be provided to residents who are unable to carry out ADLs independently.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and staff and resident interview, the facility failed to provide an activities program that supported residents in their choice of activities. This affected one resident (#57) of two residents sampled for activities. The facility census was 65.Based on medical record review, review of the activity participation document, staff and resident interview, and policy review, the facility failed to provide an activities program that supported residents in their choice of activities. This affected one resident (#57) of two residents sampled for activities. The facility census was 65.Findings Include:Record review for Resident #57 revealed this resident was admitted to the facility on [DATE] with the following diagnoses: malignant neoplasm (cancer) of the bladder, COVID-19, chronic heart failure, chronic obstructive pulmonary disease, Parkinson's disease, type 2 diabetes mellitus, and chronic kidney disease.Review of the Significant Change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #57 had intact cognition, evidenced by a Brief Interview for Mental Status (BIMS) score of 13. Resident #57 required substantial to maximum assistance with chair-to-chair transfer and dressing, and was dependent with footwear and transitioning from sitting to standing.Review of the care plan dated 08/17/25 for Resident #57 revealed the following care-planned items and interventions: Resident #57 was at risk for alteration in activity, with interventions to monitor for changes in activity participation, provide 1:1 activities as needed, provide items for self-directed activities, encourage the resident to experience and learn new activities, and assess and reassess activity interests as indicated.Interview with Resident #57 on 12/01/25 at 10:41 A.M. revealed the resident stated the facility did not provide enough activities. The resident further stated they would like to attend bingo but were not invited.Review of activity participation documentation for October 2025 and November 2025 for Resident #57 revealed the resident was marked as unavailable 71 times and refused 15 times. Documented activities the resident participated in included independent current events, independent active socializing, and independent active television.Interview with the Administrator on 12/03/25 at 3:30 P.M. verified Resident #57 was marked as unavailable on the activity participation documentation. The Administrator further verified Resident #57 was on hospice and was almost always in the facility. Additionally the Administrator was unable to explain why the resident was marked as unavailable for activities.Review of the policy titled Activities, dated 09/2020, revealed activities were to be offered based on individual resident preferences and needs. The policy further stated residents were encouraged, but not required, to participate in activity programming and that activity participation was documented in the medical record.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, staff interview, and review of The International Pharmacopoeia guidance, the facility failed to ensure the resident's eye drops that were open were not used beyond four weeks of open date and failed to ensure all eye drops that were opened had an open date. This affected two of three medications cards observed for medication storage. This affected six residents (#12, #23, #27, #46, #54, and #56) reviewed for medication storage. The facility census was 65.Findings include: Observation on 12/02/25 at 9:02 A.M. of the east medication cart revealed artificial tears lubricant eye drop 0.5 ounce (oz) one-eighth full with open dated of 08/27/25 for Resident #12 and latanoprost solution 0.005% one-eighth full no open date with a delivered date of 10/04/25 for Resident #56. Interview on 12/02/25 at 9:11 A.M. with Licensed Practical Nurse (LPN) #122 verified there were no open date on the eye drops for Resident #56 and the bottle was almost empty and the eye drops for Resident #12 was dated 08/27/25. Observation on 12/02/25 at 9:30 A.M. of the north medication cart revealed artificial tears lubricant eye drops half full with an open date of 10/25/25 for Resident #54, artificial tears lubricant eye drops half full with an open date of 10/22/25 for Resident #23, artificial tears lubricant eye drops one-fourth full with an open date of 09/25/25 for Resident #46, erythromycin ointment five milligrams three-fourths full no open date of Resident #46, and ofloxacin drops 0.3% one-fourth full with an open date of 09/10/25 for Resident #27 Interview on 12/02/25 at 9:45 A.M. with LPN #130 verified Resident #54's eye drops had an open date of 10/25/25, Resident #23's eye drops had an open date of 10/22/25, Resident #46's eye drops had an open date of 09/25/25, Resident #46's eye drops were open with no opened date, and Resident #27's eye drops had an open date of 09/10/25. Review of The International Pharmacopoeia, twelfth edition, 2025 revealed multidose ophthalmic drop preparations may be used for up to four weeks after the container is initially opened.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to follow the menu for residents on a puree diet. This had the potential to affect three residents (#9, #12, and #54) who receive a puree diet . The facility census was 65. Findings include:Review of the lunch menu for 12/04/25 revealed residents on a puree diet should receive pureed tomato soup with crackers, pureed ham and cheese sandwiches, and pureed cantaloupe. Observation of the lunch service on 12/04/25 at 11:56 A.M. revealed the residents on a puree diet were being served tomato soup, pureed ham and cheese sandwiches, and cottage cheese. Interview on 12/04/25 at 12:10 P.M. with Dietary Director #169 verified the residents on a puree diet were served regular tomato soup without crackers and apple sauce instead of pureed cantaloupe. Review of the facility policy titled Texture and Consistency- Modified Diets dated 2021 revealed texture modification diets would be followed and changes should not be made without a written order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365532	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ayden Healthcare of Greenville	243 Marion Drive Greenville, OH 45331

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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 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 observations, staff interviews, and facility policy review, the facility failed to prepare food in a safe and sanitary manner to protect against foodborne illness. This had the potential to affect all 65 residents residing in the facility as the facility did not identify any residents with an order of nothing by mouth. Findings include:Observation of the preparation of puree diets and interview on 12/04/25 at 11:19 A.M. revealed [NAME] #102 cleaning the food processor in the three compartment sink. [NAME] #102 immediately assembled the food processor and added sandwiches without allowing the food processor to air dry prior to placing food in the processor. [NAME] #102 verified she did not allow the food processor to dry before adding food and the inside of the food processor was still wet with sanitizer. Observation on 12/04/25 at 11:25 A.M. revealed the ham and cheese sandwiches stored on the steam table were 125 degrees Fahrenheit (F). [NAME] #102 verified the sandwiches were 125 degrees F and that minimum hot holding temperature should be 135 degrees F. At 11:56 A.M., [NAME] #102 checked the temperature of the ham and cheese sandwich prior to lunch service. [NAME] #102 verified ham and cheese sandwiches were at 132.8 degrees F. Observation on 12/04/25 at 12:02 P.M. revealed [NAME] #121 placing silverware on resident's lunch trays without gloves. Spoons were observed in a plastic container and unorganized. [NAME] #121 was observed touching the mouth-contact surface of other spoons when removing a spoon from the container. Interview with DD #169 verified the spoons were unorganized in the container and reorganized them to prevent contamination. Review of the facility policy titled General Food Preparation and Handling dated 2021 revealed food items will be prepared to conserve maximum nutritive value, develop, and enhance flavor and keep free of harmful organisms and substances.

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	365532	A. Building B. Wing	12/04/2025

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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, record review, review of Centers for Disease Control and Prevention (CDC) guidance, and facility policy review, the facility failed to ensure staff wore the appropriate personal protective equipment (PPE) for residents who were in Enhanced Barrier Precautions (EBP). This affected one (Resident #3) of two residents reviewed for EBP. The facility census was 65. Findings include: Record review revealed Resident #3 was admitted on [DATE]. Diagnoses included active primary progressive multiple sclerosis, and epilepsy (seizures). Review of the weekly wound assessment dated [DATE] revealed Resident #3 had a pressure ulcer (wound from constant pressure to the skin) stage IV (pressure ulcer with bottom extending to the muscle or bone) on the sacrum (tailbone). The active physician orders for Resident #3 for December 2025 reveled an order for EBP due to wound and indwelling catheter. Observation of Certified Nursing Assistant (CNA) #164 on 12/03/25 at 12:53 P.M. revealed CNA #164 coming out from behind Resident #3's curtain without a gown on. During an interview on 12/03/25 at 12:53 P.M., CNA #164 stated they just finished changing Resident #3's brief and performing peri-care. CNA #164 verified the two CNAs did not wear a gown. CNA #164 confirmed they should have been wearing a gown due to the EBP. Review of the policy titled Enhanced Barrier Precautions (EBP) dated 04/01/24 revealed for residents for whom EBP are indicated, EBP is employed when performing high contact resident care activities including changing briefs. Review of CDC guidance titled Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) found at https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html and dated 04/02/24 revealed MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. EBP is an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status.

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	365532	A. Building B. Wing	12/04/2025

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure a resident's call light was in working order. This affected one (#55) of 24 residents reviewed for call lights. The facility census was 65. Findings include:Review of Resident #55's medical record revealed Resident #55 was admitted to the facility on [DATE]. Diagnoses included Parkinson's disease without dyskinesia and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #55 was moderately cognitively impaired and was dependent on staff with toileting, personal hygiene, and transfers. Review of the fall care plan dated 10/30/25 revealed Resident #55 was at risk for falls. Interventions included to ensure the call light was in reach. Observation of Resident #55's room on 12/01/25 at 10:28 A.M. revealed Resident #55's call light was not functioning or turning on in the room, hallway, or nursing station. Interview on 12/01/25 at 10:28 A.M. with Maintenance Director #155 verified Resident #55's call light was not functioning or turning on in the room, hallway, or nursing station. Review of the facility's call light policy dated August 2021 revealed staff should notify maintenance if call lights were not functioning.