| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 365539 | A. Building<br>B. Wing | 12/31/2025 |

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| Warren Nursing & Rehab | 2473 North Rd NE<br>Warren, OH 44483 |

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

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| F 0880<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, closed medical record review, review of the facility water management plan and maintenance logs, review of the Centers for Disease Control and Prevention (CDC) guidance related to legionella, review of infection control tracking, and interviews with staff and representatives from the Local Health Department (LHD), the facility failed to develop, implement and follow a comprehensive and effective infection control/water management plan and remediation program to prevent the risk of legionella growth and spread in the water supply. This resulted in Immediate Jeopardy and the potential for serious life threatening harm, negative health outcomes, and/or death beginning on [DATE] when Resident #76, who was bed ridden, had chronic lung disease, was dependent on a mechanical ventilator to breath, and had not left the facility for over 14 days prior to hospitalization, became unresponsive and in respiratory distress requiring emergency transfer to the hospital where she was diagnosed with septic shock, pneumonia and subsequently tested positive (on [DATE]) for legionella pneumophila Ag bacteria in her urine (a rapid urine antigen test used to diagnose Legionnaire's disease, a severe form of pneumonia caused by legionella bacteria) and expired in the hospital on [DATE]. The facility's failure to develop, implement and follow a comprehensive and effective infection control/water management plan and remediation program to mitigate the growth of legionella affected one resident (#76) and placed all 72 current residents in the facility at risk of developing serious life-threatening illness and/or death from Legionnaire's disease.In addition, a concern that did not rise to the level of Immediate Jeopardy was identified when the facility failed to maintain proper infection control practices to prevent the spread of infection. Respiratory Therapist (RT) #364 was observed providing suctioning and tracheostomy care to Resident #18, who was in contact isolation for Clostridium Difficile (C Diff) infection (an infectious and highly contagious diarrhea) without wearing proper personal protective equipment (PPE). This affected Resident #18 and had the potential to affect 11 additional residents (#1, #2, #10, #11, #22, #25, #38, #42, #58, #62, and #65) who resided on the Aspen unit. The facility census was 72.On [DATE] at 2:25 P.M. the Administrator, Director of Nursing ( DON) , Regional Director of Operations (RDO) #801, [NAME] President of Clinical Services (VPCS) #802, and Regional Director of Clinical Services (RDCS) #803 were notified Immediate Jeopardy began on [DATE] when Resident #76 was transferred to the hospital due to respiratory distress and subsequently tested positive for Legionella. Resident #76 expired in the hospital on [DATE]. The facility failed to develop and implement an effective water management program to address areas of water stagnation, plumbing schematics and comprehensive assessment of the physical plant with lack of control measures and remediation/investigation therefore exposing risk of legionella growth and spread to the residents in the facility.The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions:-<br>On [DATE] at 10:42 A.M. Registered Nurse (RN) #431 was contacted by the Local Health Department for notification that Resident #76, who had resided on the Aspen unit in the facility, tested positive for Legionella while at the hospital and expired at the hospital. RN #431 immediately notified the Medical Director, Administrator, Director of Nursing (DON) and Infection Control Physician. - On [DATE] at approximately 11:00 A.M. the Administrator, DON, Assistant Director of Nursing (ADON) and Human<br>(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 0880<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Resources instructed via electronic and in-person huddles for staff to avoid unflushed/restricted water and to use alternative (bottled or approved) water and ice. - On [DATE] at approximately 11:30 A.M. the Administrator, Maintenance Director #368 and Dietary Director #317 implemented bottled water for all drinking and cooking. - On [DATE] at 11:30 A.M. the use of ice machines, showers, whirlpool tub, hoppers were restricted on the Aspen unit and on the Birch, Dogwood, Crabapple units only bed baths with provided wipes were permitted as use of showers was restricted. - Between [DATE] and [DATE] the Administrator, DON, ADON and Human Resources provided staff education to six of six RNs, 18 of 27 Licensed Practical Nurses (LPN), 37of 52 certified nursing assistants (CNA), 10 of 10 Housekeepers, five of five Activity staff, seven of seven Respiratory Therapists (RT) , and agency staff including one RN, 21 LPNs, and 31 CNAs. The education included the Centers for Disease Control Legionella signs and symptoms, transmission, surveillance/detection, and the facility's water management program. Education was completed by [DATE]. For any staff not on the schedule due to leave or other reasons, education would be provided prior to start of next shift. - On [DATE] by 3:00 P.M. the DON and Registered Nurse (RN) #350 assessed all current residents for signs/symptoms of legionella infection (cough with phlegm, chest pain, fever, chills, and shortness of breath).- On [DATE] 500 gallons of water was delivered to the facility by commercial provider. - On [DATE] bags of ice were delivered by commercial provider. - On [DATE] at approximately 11:30 A.M. use of ice machine, sinks, showers, whirlpool tub, and hoppers were restricted on the remaining units of Birch, Crabapple, Dogwood and Somerset. - On [DATE] at approximately 12:30 P.M. a phone call was held with the local health department and Ohio Department of Health Bureau of Environmental and Radiation Protection for guidance on (legionella) mitigation and testing. - On [DATE] at 5:00 P.M. six portable handwashing sinks were delivered and stationed on Aspen unit. - On [DATE] by approximately 6:00 P.M. signage was posted by VPCS #806, RDCS #803, the DON, ADON and Respiratory Therapy Director instructing staff to avoid unflushed/restricted water and to use alternative (bottled/approved) water. - On [DATE] ServPro performed professional attic cleaning on the Aspen unit including debris removal, HEPA vacuuming, antimicrobial treatment, stain/odor blocking sealant application, air/surface testing, removal of wet insulation, ceiling repair below the attic and vent pipe repair within the Aspen unit Hallway/Attic area between rooms 503, 508, 502, 509, 510 and 501. - On [DATE] at approximately 10:30 A.M. a phone call meeting was held with a legionella consultant to review the facility water management plan.- On [DATE] at 7:00 P.M. 16 portable handwashing stations were delivered and stationed throughout the facility. - On [DATE] the Maintenance Supervisor (MS) #368 installed 10 legionella prevention filters on the Aspen unit (in the shower room, medication room and rooms 501, 502, 503, 504, 505, 506, 507, 509, 510, 515, 516, 517, 518 and 519). - On [DATE] at 4:37 P.M. Regional Director of Operation completed Somerset unit water flush which included full flushing of all pipes, bathrooms, sinks, hoppers and dialysis den. Documentation was submitted to the Administrator. - On [DATE] at 5:00 P.M. an Ad Hoc Quality Assessment and Performance Improvement (QAPI) meeting was held with the Medical Director, VPCS, RDO, RDCS, Administrator, DON, MDS, Housekeeping, MS #368, Human Resources, RN #431 and the ADON for QAPI tracking including weekly flushing compliance, audit outcomes, symptom surveillance, environmental concerns, legionella water management program review and risk assessment analysis review. - On [DATE] MS #368 installed additional legionella prevention filters to two hand sinks in dialysis, one hand sink in the therapy gym, one hand sink in the first floor public rest room, one hand sink in laundry and six sinks in the kitchen, one sink in the Birch, Dogwood, Crabapple medication rooms, one sink in the first floor dining room, one sink in the Dogwood shower room and the Crabapple room sinks in rooms 710, 716 and 718.- On [DATE] at 6:00 P.M. the RDO re-educated MS #368 on weekly flushing, documentation rules, proper procedures (15 minutes run time, full toilet flush/hopper flush) and reporting/escalation steps. - On [DATE] the RDO contacted an additional Legionella Consultant #901 for mitigation support. - On [DATE] Legionella Consultant #901 performed water testing of 25 samples collected across Aspen, Birch, Crabapple, Dogwood and Somerset units. - The (continued on next page) |

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| F 0880<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | facility implemented a plan for clinical monitoring beginning [DATE] by the DON/ADON or designee to review resident documentation weekly for four weeks for symptoms such as temperature, pulse, respirations, blood pressure, oxygen level, lung sounds, cough and phlegm, chest pain, fever/chills, shortness of breath. - The facility implemented a plan for environmental monitoring by the Administrator or designee beginning [DATE] to review flushing logs weekly for four weeks and monthly thereafter. - The facility implemented a plan for enhanced surveillance by the DON/ADON beginning [DATE] to include a 20 day enhanced respiratory illness monitoring and immediate reporting of suspected cases. - The facility implemented a plan for the water management program beginning [DATE] to be on-going and include daily monitoring of temperature, disinfectant levels, flushing logs, legionella filters for placement and function twice a day and monthly Water Management Plan meetings until investigation closed. Although the Immediate Jeopardy was removed on [DATE] the deficiency remained at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance.Findings include:1. Review of the closed medical record for Resident #76 revealed an admission date of [DATE] with diagnoses including myotonic muscular dystrophy, chronic obstructive pulmonary disease, morbid obesity with alveolar hypoventilation, cardiomyopathy, congestive heart failure, atrial fibrillation, tracheostomy, chronic kidney disease, and dependence of respirator ventilator status. Resident #76 was discharged from the facility on [DATE] to the hospital where she expired on [DATE].Review of the plan of care for Resident #76, date revised [DATE], revealed the resident was a full code, was dependent on mechanical ventilation with a tracheostomy and had a self-care deficit related to myotonic muscular dystrophy, history of cerebral vascular accident, chronic respiratory failure with vent/trach dependence, impaired mobility, and morbid obesity. Interventions included provide full resuscitative measures, monitor/document respiratory rate depth, quality every shift/as ordered, oxygen settings as ordered, suction as necessary, transfer with two assist mechanical lifts, set-up assist for eating, and assist with activities of daily living.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #76 had intact cognition, required (staff) set-up and clean-up assistance for eating, was totally dependent on staff for oral hygiene, toileting, bathing, dressing, bed mobility and transferring. Resident #76 was incontinent of bowel and bladder, had respiratory failure with a tracheostomy and required mechanical ventilation.Review of a nursing note, dated [DATE] at 1:40 P.M. and authored by Licensed Practical Nurse (LPN) #379 revealed at approximately 11:50 A.M. the Certified Nursing Assistant (CNA) responded to Resident #76's call light and noticed Resident #76 appeared cyanotic (bluish discoloration of skin, lips, nails due to lack of oxygen). The CNA immediately called the nurse to the room. Upon entering the room, immediately assessed the resident and her oxygen saturation was 45 percent (normal 90-100%). The nurse promptly suctioned the resident and began bagging. The residents' oxygen saturation improved to 100 percent. Resident #76 was placed back on the ventilator; however, her oxygen saturation began to drop. Another nurse on duty contacted the emergency medical team (EMT) for emergency transport. Bagging continued until EMT arrived and assumed care. The supervisor on call, physician and family was notified.Review of the Transfer Form dated [DATE] at 1:46 P.M. and completed by LPN # 828 revealed Resident #76 was sent to the hospital on [DATE] at 12:00 P.M. from the Aspen unit due to unresponsiveness. The transfer was an unplanned transfer.Review of the Change in Condition Evaluation, dated [DATE] at 1:57 P.M. completed by LPN #828 revealed Resident #76 was short of breath, and unresponsive (which began on [DATE]). Blood pressure was 152/90 (hypertensive). Respirations were greater than 26 per minute, 93 percent oxygen saturation by the vent. Resident #76 was a full code. Shortness of breath was an abrupt change, and oxygen dropped to 35 (%), skin became discolored with a bluish tone. Resident then became unresponsive. No abnormal labs to report. Reported to primary care clinical on [DATE] at 12:11 P.M. Review of the Change in Condition Evaluation dated [DATE] at 7:38 P.M. authored by Registered Nurse (RN) #399 revealed Resident #76 (continued on next page) |

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| F 0880<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | had a respiratory infection, shortness of breath, tired/weak/confused/drowsy. Blood pressure was 108/71, pulse was 104, pulse oximetry was 88 percent. Physical assessment revealed increased confusion, weakness, shortness of breath, and difficult to arouse. Nursing observation included Resident #76 recent arrival back into the facility from the hospital, SpO2 (peripheral capillary oxygen saturation) dropped, arterial blood gas (ABGs) were drawn by Respiratory Therapy (RT). Family was at bedside and made aware resident returned from the hospital with diagnosis of pneumonia. Family aware physician wanted Resident #76 sent back to the hospital because she should have been admitted . Resident #76 had an abrupt change in mental status abnormal ABGs, oxygen levels dropped, with increased respiration and low SpO2.Review of a nursing note, dated [DATE] at 7:40 P.M., authored by RN #399 revealed Resident #76 returned from the hospital. Resident #76 oxygen desaturated down to 84. Oxygen was turned up to 10 liters. SpO2 went to 91 then down to 87. ABGs were drawn with poor results. Paperwork from the hospital stated Resident #76 had pneumonia. Pulmonary doctor was consulted and stated to send Resident #76 back to the hospital. 911 was called.Review of assessment titled Discharge to Hospital Form, dated [DATE] at 8:07 P.M. revealed report was called in to the hospital at 10:19 P.M.Review of the Respiratory Therapy Note dated [DATE] at 8:12 P.M., revealed Resident #76 was re-admitted to the facility when the RT arrived for shift. After the paramedics left, nursing performed an assessment and discovered Resident #76 had a SpO2 of 82 percent. Pulse oximeters were attempted on multiple fingers with no variations. The RT decided to increase oxygen to 10 milliliters per minute. Resident #76's oxygen increased to 85 percent. Resident #76 oxygen saturations increased to 87 percent but then Resident #76 became lethargic. ABGs were drawn from the right radial artery with no complications. Physician was called with results and was notified of the situation. Physician said to send Resident #76 to the hospital to have her admitted .Review of the hospital records for Resident #76 dated [DATE] revealed a chief complaint of low pulse oximeter readings. The principal problems listed included septic shock, morbid obesity, sepsis due to pneumonia, acute on chronic respiratory failure with hypoxia and hypercapnia, shortness of breath, and sepsis with acute hypoxic respiratory failure. Urine legionella antigen was collected on [DATE] and the results were positive for Legionella Pneumophilla Ag in the urine (reference range negative). Discharge diagnoses included intractable ventricular tachycardia, septic shock due to ventilator associated pneumonia resulting in acute on chronic hypoxia/hypercapnic respiratory failure, acute renal insufficiency. Resident #76 expired at the hospital on [DATE] at 8:17 A.M.Review of a facility map revealed Resident #76 had resided on the second floor of the facility on the Aspen unit (the ventilator unit). On the first floor of the facility was an unoccupied, former resident unit identified as Somerset (which was noted by the facility Maintenance Supervisor as closed down after it was affected by a flooding of water in the facility in [DATE]).Review of the Legionella Water Management Program, updated [DATE], revealed it was the policy of the facility to establish water management plans for reducing the risk of legionella and other opportunistic pathogens in the facility's water supply. The facility must designate a team responsible for overseeing the water management program who have expertise in infection control, facility management and maintenance as well as outside consultants if needed. The water management program should be under ongoing review to account for changes in the facility's water systems. Hot water temperatures should be continuously monitored and maintained at 140 degrees Fahrenheit (F) or higher to prevent legionella growth, however, to avoid scalding should be delivered at 120 degrees F. Water flow should be controlled to prevent stagnation. Water systems should be regularly flushed especially in low use areas such as unused faucets, showers or sections of plumbing. Regular cleaning and maintenance of cooling towers and HVAC systems should be inspected, cleaned and disinfected regularly to prevent legionella growth. There was no evidence in this document that it had been revised or updated to reflect control measures in place for the Somerset unit after the flood and closing down the unit in [DATE]. There was no written description of how the facility water was supplied, heated, stored, recirculated, mixed or moved between floors.Review of a facility document (continued on next page) |

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| F 0880<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | titled Logbook Documentation Task Name: Testing and Monitoring of Water Management Plan for Legionella, dated [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE], completed by Former Maintenance Director #821 revealed multiple locations in the facility were given a pass rating, however, there were no specifications listed to explain what was evaluated. There were no additional documents with this title after [DATE].Review of a facility document titled Water Management Risk Assessment and Analysis dated [DATE], revealed the water management team (the Administrator, Medical Director, Director of Nursing, Infection Preventionist and Maintenance Director) was responsible for oversight and consultation regarding potential risks exposure prevention and training. The team would develop and maintain a hazard analysis and critical control point plan. The facility administrator and Director of Nursing were responsible for buildings where water systems are present and were responsible for ensuring components of the legionella exposure control plan are developed and current and providing applicable employee training where there is a potential risk of legionella being present. Incoming water was from the city of [NAME]. There was no written description of how the facility water was supplied, heated, stored, recirculated, mixed or moved between floors. Under Facility Control Procedures it was noted the water management plan (WMP) was developed to reduce the risk for legionella growing and spreading to the facility population at higher risk for Legionnaires disease. The facility had chosen control measures as followed: pipework with lack of water flow or stagnation can cause risk for bacterial growth. Weekly flushing of water through all faucets in resident rooms, eye wash stations, and beauty shop, this task will be added to housekeepers to be completed Monday or Tuesday each week and consisting of flushing each faucet for three minutes and showers. Also flush all toilets at least once a week. The hot water system boiler temperature would be set to 140 degrees F and hot water holding tanks at 140 degrees F and facility staff would record the water temperature weekly. Supervision to review documentation by Thursday each week to ensure compliance and if not being done the task would be scheduled to be done by Friday. There was no standardized form attached for recording consistent measures to review or who was responsible to review for remediation. Review of a facility document titled Legionella/Hand Water, dated [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE], completed by Maintenance Supervisor (MS) #368 revealed multiple locations in the facility were given a pass rating, however, there were no specifications listed to explain what was evaluated. Review of a facility provided document Metiri Analytical Group (previously known as CWM Environmental Cleveland, LLC) Analytical Report, date reported [DATE], revealed on [DATE] eight water samples were taken from the Birch unit bathing facility, Birch unit room [ROOM NUMBER], the Aspen unit nurses station, Aspen unit bathroom, Dogwood bathroom, Dogwood bathing facility, Crabapple bathroom and Crabapple bathing facility. The result was less than 0.100 Most Probably Number per milliliter (MPN/ml) for legionella pneumophila group. There were no samples taken from the Somerset unit. Review of email correspondence dated [DATE] at 1:33 P.M. authored by Environmental Specialist (ES) #813 revealed ES #813 was contacting the local health department (LHD) of [NAME] City to provide guidance on a legionella case positive at the facility, as it was in the LHD jurisdiction. The case was considered a presumptive healthcare associated case, so ES #813 asked the facility to follow the Center for Disease Control (CDC) guidance for a full investigation and to set up a call to go over the following steps on [DATE] at 12:30 P.M. with the facility: Contact aˆLegionellaˆconsultant to assist with installing filters, assisting with sample collection, conducting a facility assessment, and water systems. Please see the attached list of active consultants in Ohio.ˆˆˆ Implement water-use restrictions throughout the facility using point-of-use filters (0.2 microns). ODH recommends using filters graded for at least 60 days during the investigations. Filters should be installed within two to three days after receipt of this email. Working with their consultant, they may either install these filters on all fixtures in the building or on key locations and restrict water access everywhere else. Communicate to staff and residents about water restrictionsˆand post signage near each fixture with a filter for people to contact maintenance staff if a filter is damaged or<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | removed.ˆCDC provides communication resources on their website.ˆˆˆ Conduct a new risk assessment of the facility, it is recommended to complete a CDCˆLegionellaˆEnvironmental Assessment Form (LEAF). Send the completed assessment form to ODH andˆthe local health districtˆwhen done.ˆˆˆ Create aˆLegionellaˆsampling plan for their facility. These will be consideredˆpre-remediationˆsamplesˆand will follow CDC guidance for samples collected during an investigation. Samples should be a combination of flush (bulk water) and first draws/swabs (see CDC sampling guidance). Water samples should be collected in 1L bottles and sent to a CDC ELITE Certified Laboratory. Make sure samples are evenly distributed and include all water sources in each of the case rooms.ˆBuildings with multiple floors should have at least two sample locations on each floor. Buildings with risers should assure there is at least one point of use sampling location on each riser.ˆMany consultants are familiar with ODH sample expectations. Send the sampling plan to ODH with locations marked on a facility map prior to sample collection. Videos and additional sampling resources are found on the CDC webpage. After samples are collected, implement any identified corrections to the potable water system to prevent water stagnation and/or improve water flow.ˆRemediate/treatˆthe facility's water system following the guidance of their consultant. Collect a set of samples at the same locations as the previous set 72-hours after remediation.ˆThese will be considered post-remediation samples.ˆCollect additional sets every two weeks until the facility has two consecutive negative sample sets.ˆˆˆ The facility should revise their water management program based on ODH andˆlocal health districtˆrecommendations. Their consultant may help with this.ˆWe tend to return WMPs within 3-4 weeks of receipt.ˆ Review of a facility document provided by the Director of Nursing (DON) on [DATE] revealed a single page document with one typed line that stated all residents have been assessed on [DATE] with no signs of respiratory distress noted. The documentation was signed by the DON. There were no resident names or clinical indicators of what the assessments consisted of on the document. Review of the facility document tilted Water Temperature Log dated [DATE] to[DATE] revealed water temperatures were taken at the same time on four separate resident units but did not specify if the temperatures were taken from the holding tanks or faucets. Review of the Centers for Disease Control (CDC) website (https://www.cdc.gov/investigate-legionella/php/healthcare-resources/control-measures.html) dated [DATE] titled Implementing Control Measures In Healthcare Facilities , revealed examples of immediate control measures included until the investigation is completed avoid creating aerosols by avoiding exposure to hydrotherapy tubs, avoiding use of water from sink/tub faucets in patient rooms, restrict showers(use sponge baths), and limit consumption of non-sterile ice for anyone at risk of aspiration or who has swallowing difficulties. Review of the document titled Q Laboratories Legionella Sample Submission Form, dated [DATE] revealed Legionella Consultant (LC) #811 collected 26 samples from the facility with results reported [DATE]. The ISO legionella results were none detected.Review of the document titled Q Laboratories Final Report, dated [DATE], revealed ISO legionella results were none detected.An interview on [DATE] at 9:18 A.M. with Maintenance Supervisor (MS) #368 revealed the local health department was to call in today at 2:00 P.M. with instructions regarding a resident who tested positive for Legionella. The facility tested the water for legionella on [DATE] and it tested negative and retested on [DATE] because the resident tested positive for legionella.An interview on [DATE] at 9:20 A.M. with the Administrator revealed according to the Center for Disease Control guidelines the facility could wash hands and give bed baths with faucet water with no filters. The Administrator stated because Resident #76's urine tested positive for legionella it could be a false positive. The Administrator verified the health department notified the facility on [DATE] that Resident #76 had tested positive for legionella in the urine.An interview with MS #368 on [DATE] at 9:45 A.M. revealed the facility was using bottled water for drinking and using tap water for the laundry, cooking and the dish machine. MS #368 stated no residents had showers since [DATE], and the DON was to educate nursing staff on resident protocol. Observation on [DATE] at 9:50 A.M. with MS #368 of Resident #76's room revealed the sink still had running water, (continued on next page) |

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| F 0880<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | and the staff had an air mattress on the floor that was in the process of filling for another resident. MS #368 verified the room should not be in-use; however, no signs were posted to not use the room and stated no one was in the room and staff should know not to use the sink.Observation on [DATE] at 9:50 A.M. to 10:30 A.M. with MS #368 revealed no signage was posted at the nurse's stations or anywhere on the Birch, Dogwood, Crabapple or Aspen units to alert staff to not use water from the sink faucets. MS #368 stated the nurses were to use a water pitcher to wash hands with water brought in instead of water from the faucets. Observation on [DATE] at 10:00 A.M. with MS #368 present during the observation revealed the attic area above Resident #76's room presented with moldy drywall, a dead animal carcass, an open white pipe dripping water, wet and moldy insulation and signs of standing water on the floor of the attic. There were also signs of water damage on the ceiling. MS #368 verified the findings at the time of the observation.An interview on [DATE] at 10:25 A.M. with LPN #380 revealed nurses were approved to wash hands in the sinks and use the water from the sinks for resident care because it did not cause an aerosol.An interview on [DATE] at 10:30 A.M. with LPN #319 revealed the nurses were told it was okay to wash hands in the sinks of resident's rooms and the water bottles were to be used for resident drinking water.An interview on [DATE] at 11:12 A.M. with Epidemiologist #804 from the local health department revealed the department was notified by the local hospital on [DATE] that a resident (Resident #76) died in the hospital who tested positive for legionella. The local health department notified the Ohio Department of Health (ODH) Environmental Health unit on [DATE] and awaited direction from ODH Environmental Health prior to contacting the facility. The facility was contacted on [DATE] with an urgent message to have the infection control nurse call the local health department but no call was received from the facility. On [DATE] Epidemiologist #804 called the facility again and was able to speak with Infection Control Nurse #431 to notify the facility a resident from their facility tested positive for legionella in the hospital and expired in the hospital. Epidemiologist #804 asked the facility if Resident #76 had left the building 14 days prior to admission to the hospital on [DATE]. The facility reported Resident #76 had not left the facility 14 days prior to the hospital admission. Epidemiologist #804 stated she would call back to set up a meeting on the next steps the facility was to abide by which was scheduled for 2:00 P.M. on [DATE]. Epidemiologist #804 stated the facility would be instructed to hire a legionella consultant and a list would be provided.On [DATE] at 1:20 P.M., observation during the facility tour revealed a large ceiling stain near Resident #76's room in the hallway on the Aspen unit by the exit sign and a black substance around the pipes in the hallway. Interview with the MS #368 at the time of the observation revealed the stain was from a roof leak about a month ago. When asked if water got inside the air duct work he stated, yes, but we had a company come replace the duct work.An observation was conducted on [DATE] at 1:24 P.M. of the attic on the even room number side of the Aspen unit to inspect the stained area. Observation revealed duct work was not replaced, a plastic drain pipe was disconnected, wet insulation removed from the duct work was left in the area, and signs of what appeared to be water stains and mold on drywall. Observation also revealed a decomposed rodent resembling an opossum outside of Resident #76's room in the ceiling. Photographs were taken at the time of the observation by the life safety surveyor and verified by MS #368. MS #368 stated the air flow from the attic ran into Resident #76's room. An interview and observation were conducted on [DATE] at 2:06 P.M. with MS #368 of the Somerset unit. MS #368 stated the Somerset unit had been flooded by creek water back in [DATE] and had not been in use for some time. When asked about stagnant water lines/deadlines on the unit, MS #368 stated the water is shut off. Observation of water faucets in the mop closet and the shower room at 2:10 P.M. on the Somerset Unit, revealed the water was still turned on to that part of the building. MS #368 verified the taps and pipes were not being flushed on that unit. MS #368 verified there were no other log books of documentation to review regarding testing and monitoring for the water management plan. A request for water flushing logs was made at this time and MS #368 stated there were no logs to prove flushing was being done on the Somerset unit. Despite his prior statement that the water to the [TRUNCATED] |

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| | 365539 | A. Building<br>B. Wing | 12/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Warren Nursing & Rehab | 2473 North Rd NE<br>Warren, OH 44483 |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, facility policy review and interview, the facility failed to develop and implement a comprehensive and individualized pressure ulcer prevention program to prevent and/or promote pressure ulcer healing. The facility failed to ensure pressure-relieving equipment was functioning as intended, failed to ensure nutritional interventions were initiated, and failed to ensure treatments were implemented and maintained as ordered to prevent the development and/or worsening of pressure ulcers for Residents #10, #11, #25, #27, #44, and #58. Actual Harm occurred beginning on 11/19/25 when Resident #10 who was severely cognitively impaired and at high risk for pressure ulcer development with a history of pressure ulcers developed a deep tissue injury (DTI)/unstageable (full thickness tissue loss) pressure ulcer to the thoracic spine (mid-back) as a result of a malfunctioning low air loss (LAL) mattress. Actual Harm occurred on 12/09/25 when Resident #27 who was severely cognitively impaired and at high risk for pressure ulcer development was found to have an unstageable pressure ulcer to the right ischium. The facility failed to provide evidence the resident was being adequately monitored and/or provided necessary intervention to prevent the ulcer from first being found as an unstageable pressure ulcer. This affected six residents (#10, #11, #25, #27, #44, and #58) of 15 residents reviewed for pressure ulcers. The facility census was 72.Findings include:1. Review of Resident #10's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including end stage renal disease, chronic congestive heart failure, necrotizing fasciitis, moderate protein calorie malnutrition, dysphasia, dependence on a respiratory ventilator, acute pulmonary edema, tracheostomy status, and pressure ulcer of other site Stage IV (full thickness tissue loss with exposed bone, tendon or muscle. Slough may be present on some parts of the wound bed. Often include undermining and tunneling.) to the coccyx.<br><br>Review of the resident's physician orders revealed a diet order for the resident to receive nothing by mouth (NPO). The resident had an order for enteral tube feed with Nepro at 40 milliliters (ml) per hour for 20 hours a day (high-protein nutritional supplement). An order (dated 10/30/25 for a low air loss (LAL) mattress, monitor function inflation every shift. An order to cleanse coccyx with full strength Dakin's (antimicrobial cleanser), apply full strength Dakin's on a four by four gauze cover with abdominal (ABD) pad and do not tape every shift, in-house dialysis Monday through Friday, an order for ProStat (a protein supplement for wound healing) 30 milliliters daily dated 07/22/25 and discontinued 10/10/25, an order for liquid protein three times a day dated 12/17/25 and an order for enhanced barrier precautions (EBP).<br><br>Review of the care plan dated 11/03/25 revealed Resident #10 had a documented pressure ulcer (ulcer to the coccyx). Interventions included monitoring bony prominences for redness, monitoring nutritional status, providing wound treatments as ordered and referring to a specialized practitioner for wound management. The care plan further revealed Resident #10 had the potential for impairment of skin integrity related to impaired mobility and current pressure injury to the coccyx. Interventions included encouraging Resident #10 to turn and reposition every two hours and a low air loss mattress. The mattress was to be monitored for function and inflation every shift. Additional interventions included notifying the dietitian of altered skin integrity and ensuring adequate nutrition related to wound and skin needs. Additionally, the care plan revealed Resident #10 had the potential for alteration of nutrition. Interventions included providing and serving supplements as ordered.<br><br>A dietary note dated 11/09/25 authored by Registered Dietitian/ Licensed Dietician (RD/LD) #820 revealed a recommendation for Prostat to tube feeding three times a day for low albumin (a protein<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | made in the body that supports tissue repair and maintains fluid balance) as recommended by the dialysis provider.<br><br>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of five out of 15, indicating Resident #10 had severe cognitive impairment. The MDS also revealed one Stage IV pressure area and no unstageable wounds. The assessment included a pressure-reducing device was in use.<br><br>Review of the Braden Scale assessment dated [DATE] revealed a score of 11 indicating the resident was at high risk for pressure ulcer development.<br><br>A review of wound notes authored by Certified Nurse Practitioner (CNP) #830 revealed the following:<br><br>- On 11/19/25, CNP #830 saw Resident #10 for a chronic Stage IV wound of the coccyx and was to evaluate a new thoracic spine wound. Assessment of the thoracic spine wound revealed deep tissue injury (DTI) (A purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue due to pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.) The area on the thoracic spine measured 2.5 centimeters (cm) by 3.0 cm. The thoracic spine wound was defined as facility acquired. CNP #830 further described the area as a new pressure ulcer to the thoracic spine due to LAL bed malfunction. Orders included maintenance to fix the LAL mattress.<br><br>- On 11/26/25, CNP #830 evaluated the wound to the thoracic spine. The wound was defined as an acute unstageable pressure injury (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed) with obscured full thickness skin and tissue loss. Measurements were documented as 6.0 cm by 4.0 cm. CNP #830 documented the wound as deteriorating. Interventions included maintenance to fix or replace the LAL mattress.<br><br>- On 12/03/25, CNP #830 evaluated the wound to the thoracic spine. The wound was defined as an acute unstageable pressure injury with obscured full thickness skin and tissue loss. Measurements were documented 6.0 cm by 4.5 cm. CNP #830 documented the wound as deteriorating. Interventions included maintenance to fix or replace the LAL mattress.<br><br>- On 12/10/25 CNP #830 evaluated the wound to the thoracic spine. The wound was defined as an acute unstageable pressure injury with obscured full thickness skin and tissue loss. Measurements were documented as 6.0 cm by 5.5 cm. CNP #830 documented the wound as deteriorating. Interventions included maintenance to fix or replace the LAL mattress.<br><br>- On 12/17/25, CNP #830 evaluated the wound to the thoracic spine. Measurements were documented as 5.5 cm by 5.5 cm. There was no change noted to the wound progression. Interventions included maintenance to fix or replace the LAL mattress.<br><br>A review of TELLS log (a computer system to notify and log repairs needed to the facility) dated 10/01/25 through 11/28/25 revealed on 11/19/25 the air mattress for Resident #10 was reported as having low pressure. The bed was documented as repaired on 11/19/25 at 12:42 P.M.<br><br>On 12/16/25 at 12:01 P.M. an interview with CNP #830 revealed Resident #10 developed an unstageable pressure ulcer to the thoracic spine. CNP #830 stated the unstageable pressure ulcer<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | was a direct result of the LAL mattress not functioning. CNP #830 revealed multiple work orders had been placed to fix the mattress.<br><br>On 12/17/25 at 7:56 A.M. an observation of wound care for Resident #10 with CNP #830 and Registered Nurse (RN) #431 who was identified as the facility wound nurse revealed the LAL mattress had a yellow blinking light that read low pressure, an alarm for malfunction was not sounding. CNP #830 stated the mattress was still not fixed and does not alarm for malfunction. RN #431 stated, I don't know what it is going to take to get things fixed around here.<br><br>On 12/17/25 at 10:32 A.M. an interview with Maintenance Supervisor (MS) #368 revealed the maintenance department utilized the TELLS system for identification of issues or things that needed to be repaired. MS #368 revealed LAL mattresses were the responsibility of maintenance staff to repair. MS #368 revealed Resident #10's bed was fixed but could not recall the exact repair to the mattress. In addition, MS #368 revealed he was unaware of any issues since the bed was repaired on 11/19/25. MS #368 stated there was no system in place to routinely check air mattresses. MS #368 stated when a repair was done to an air mattress, he would check it after 30 minutes and if the mattress stayed inflated, he would mark it off as repaired.<br><br>On 12/17/25 at 1:25 P.M. an interview with RN #431 revealed air mattresses were stocked in the facility. RN #431 stated Dietary Manager (DM) #317 maintained the stockroom and does the ordering for the facility. RN #431 stated DM #317 was notified through TEAMS (a computer/phone way of communicating) of needs for LAL mattresses. RN #431 stated she put the needed repairs for the LAL mattress for Resident #10 in the TEAMS system and put in for a new mattress for Resident #10 on this date (12/17/25). RN #431 further stated MS #368 had access to the TEAMS system.<br><br>On 12/18/25 at 5:00 P.M. an interview with DM #317 revealed staff would tell her if something needed fixed or ordered. DM #317 stated if something needed fixed, she just fixed it. DM #317 stated she had fixed the mattress for Resident #10 by replacing the pump two times (dates not provided).<br><br>On 12/23/25 at 10:03 A.M. an interview with RD/LD #820 revealed the protein supplement for Resident #10 was discontinued for Resident #10 after a hospitalization in October of 2025. RD/LD #820 further stated a recommendation for a protein supplement three times a day was received from the dialysis dietitian due to the resident having a low albumin level. RD/LD #820 stated she forwarded the recommendation to Assistant Director of Nursing (ADON) #350 to obtain an order from the physician. RD/LD #820 stated the recommendation for protein supplement resumption and increase was forwarded via paper and email on 11/09/25 and 12/04/25 to ADON #350.<br><br>On 12/23/25 at 11:44 A.M. an interview with ADON #350 revealed the dietitian was to notify the physician of any needed orders. ADON #350 further stated she had no recollection of protein recommendations for Resident #10. ADON #350 also stated the dietitian was not present during weekly meetings to discuss weights, wounds or recommendations.<br><br>A review of the undated policy titled Pressure Ulcer Prevention Intervention revealed the purpose of this protocol is to implement preventative skin measures for all residents based on the levels and areas of risk to include moisture, nutrition, activity, mobility, mental status, psychosocial status, and general physical condition. When the interdisciplinary team is considering interventions, facility policy, standard of practice, and resident goals, all should be reviewed and considered prior to the implementation. Interventions for preventative skin care include interventions for nutrition. These interventions include consulting a registered dietitian as needed. It is recommended that when a<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | resident is nutritionally at risk and a pressure ulcer risk the resident is offered a minimum of 30 to 35 calories per kilogram body weight per day and 1.25 kilograms of protein per day. For the residents with nutritional risk and pressure ulcer risk it is recommended to offer a high protein mixed oral nutritional supplement or tube feeding in addition to the usual diet. Interventions for residents at high risk include providing the resident with a mattress meeting the criteria for Group One if the resident does not show any sign of skin breakdown or has evidence of Stage I (Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; it's color may differ from the surrounding area.) or uncomplicated Stage II wound (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough, may also present as an intact or open/ruptured serum filled blister). Provide residents with a mattress that meets the criteria for group two if the resident has multiple Stage II wounds or uncomplicated Stage III (full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muscle are not exposed, slough may be present but does not obscure the depth of tissue loss, may include undermining and tunneling) and Stage IV wounds. Provide the resident with a mattress that meets the criteria for group three if the resident has a multiple or complicated Stage IV or unstageable pressure wounds. Group two mattresses include a LAL mattress.<br><br>2. Review of the closed medical record revealed Resident #27 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following a cerebral infarction, aphasia, diabetes mellitus type II, dysphasia, contracture of muscle of the right lower leg and left lower leg and vascular syndromes of the brain. Resident #27 expired on 12/27/25.<br><br>Review of the resident's physician orders revealed the resident's diet order was NPO and the resident had an order for enteral tube feed of Glucerna 1.5 at 45 ml per hour continuous (nutritional supplement).<br><br>Review of the care plan dated 12/04/25 revealed Resident #27 had the potential for alteration in nutrition and hydration related to cerebral infarction. Interventions included administering tube feeding as ordered. The care plan further revealed Resident #27 was at risk for pressure injuries related to decreased mobility, incontinence, and cerebral vascular accident. Interventions included administering treatments as ordered and monitoring for effectiveness, avoiding prolonged skin contact, making referrals as needed to the dietitian, and following facility policies and protocols for prevention and treatment of skin breakdown.<br><br>Review of a quarterly nutrition note dated 12/07/25 and authored by RD/LD #820 revealed no recommendations for protein intake. The note included there were no skin concerns noted.<br><br>Review of the quarterly MDS 3.0 assessment dated [DATE] revealed a BIMS score of 00, indicating Resident #27 had severe cognitive impairment/resident rarely understood. Review of the wound grid dated 12/09/25 revealed Resident #27 had a facility acquired pressure area to the right ischium that was unstageable that was first identified on 12/09/25. There was no documented evidence that the dietitian was notified of the unstageable pressure ulcer or information as to why/how the wound developed or why it was first identified as an unstageable pressure ulcer.<br><br>Review of the physician's orders revealed an order dated 12/09/25 to cleanse Resident #27's right ischium with normal saline and apply Santyl (debriding ointment) and cover with a silicone dressing every day shift and as needed. There were no orders for a protein supplement for wound healing.<br><br>Review of the wound note dated 12/16/25 revealed Resident #27 continued to have an unstageable<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | wound to the right ischium.<br><br>On 12/23/25 at 10:03 A.M. an interview with RD/LD #820 revealed she saw and reviewed residents with wounds every two weeks. RD/LD #820 verified the lack of protein orders for Resident #27 following the identification of the unstageable pressure ulcer to promote wound healing. RD/LD #820 stated she was in the facility every Saturday, and there was a paper print out of wounds for her to review. RD/LD #820 further stated when she was in facility on 12/19/25, there was no paper print out of wounds for her to review. RD/LD #820 stated she was not notified until today (12/23/25) of the wound for Resident #27.<br><br>On 12/31/25 at 11:43 A.M. an interview with RN #431 who was identified as the wound care nurse revealed she did not have computer access to print off wound reports for the dietitian. RN #431 stated RN #418 printed off wound reports and gave them to the dietitian. RN #431 stated she had no way of tracking if reports were given to the dietitian. RN #431 stated she was not part of weekly meetings to track wounds as they are conducted during wound rounds.<br><br>During the investigation, the facility failed to provide evidence the resident was being adequately monitored and/or provided necessary intervention to prevent the ulcer from first being found as an unstageable pressure ulcer.<br><br>A review of the undated policy titled Pressure Ulcer Prevention Intervention revealed the purpose of this protocol is to implement preventative skin measures for all residents based on the levels and areas of risk to include moisture, nutrition, activity, mobility, mental status, psychosocial status, and general physical condition. When the interdisciplinary team is considering interventions, facility policy, standard of practice, and resident goals, all should be reviewed and considered prior to the implementation. Interventions for preventative skin care include interventions for nutrition. These interventions include consulting a registered dietitian as needed. It is recommended that when a resident is nutritionally at risk and a pressure ulcer risk the resident is offered a minimum of 30 to 35 calories per kilogram body weight per day and 1.25 kilograms of protein per day. For the residents with nutritional risk and pressure ulcer risk it is recommended to offer a high protein mixed oral nutritional supplement or tube feeding in addition to the usual diet. Interventions for residents at high risk include providing the resident with a mattress meeting the criteria for Group One if the resident does not show any sign of skin breakdown or has evidence of Stage I (Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; it's color may differ from the surrounding area.) or uncomplicated Stage II wound (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough, may also present as an intact or open/ruptured serum filled blister). Provide residents with a mattress that meets the criteria for group two if the resident has multiple Stage II wounds or uncomplicated Stage III (full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muscle are not exposed, slough may be present but does not obscure the depth of tissue loss, may include undermining and tunneling) and Stage IV wounds. Provide the resident with a mattress that meets the criteria for group three if the resident has a multiple or complicated Stage IV or unstageable pressure wounds. Group two mattresses include a LAL mattress.<br><br>3. Review of Resident #44's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including acquired absence of the left leg above the knee, acquired absence of the right leg above the knee, gangrene, idiopathic aseptic necrosis of bilateral hands, diabetes mellitus type II, peripheral vascular disease, acute kidney failure, and moderate protein calorie malnutrition.<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of the resident's physician orders revealed an order for Med Pass (a supplement for wound healing) 120 ml two times daily. The resident also had a treatment order to cleanse coccyx with normal saline, apply Santyl, and cover with silicone dressing every night shift and as needed and a pressure reducing mattress.<br><br>Review of the care plan dated 11/11/25 revealed Resident #44 had an impairment of skin integrity. Interventions included a LAL mattress.<br><br>Review of the five-day MDS 3.0 assessment dated [DATE] revealed a BIMS score of 15, indicating Resident #44 was cognitively intact. The MDS also revealed a Stage IV pressure area and a pressure reducing mattress.<br><br>A review of wound care notes revealed a LAL mattress was ordered on 12/02/25 for Resident #44.<br><br>On 12/16/25 at 10:15 A.M. an observation of wound care for Resident #44 revealed a LAL mattress with a low-pressure light blinking and a beeping sound coming from the air pump inflating the mattress. Resident #44 was noted to be sunk into the middle of the mattress. CNP #820 verified the bed malfunction and the position of Resident #44 at the time of the observation. Resident #44 stated the mattress had been alarming for about 30 minutes or so. CNP #820 stated the bed needed fixed, and mattress malfunction was an issue in the facility.<br><br>A review of the undated policy titled Pressure Ulcer Prevention Intervention revealed the purpose of this protocol is to implement preventative skin measures for all residents based on the levels and areas of risk to include moisture, nutrition, activity, mobility, mental status, psychosocial status, and general physical condition. When the interdisciplinary team is considering interventions, facility policy, standard of practice, and resident goals, all should be reviewed and considered prior to the implementation. Interventions for preventative skin care include interventions for nutrition. These interventions include consulting a registered dietitian as needed. It is recommended that when a resident is nutritionally at risk and a pressure ulcer risk the resident is offered a minimum of 30 to 35 calories per kilogram body weight per day and 1.25 kilograms of protein per day. For the residents with nutritional risk and pressure ulcer risk it is recommended to offer a high protein mixed oral nutritional supplement or tube feeding in addition to the usual diet. Interventions for residents at high risk include providing the resident with a mattress meeting the criteria for Group One if the resident does not show any sign of skin breakdown or has evidence of Stage I (Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; it's color may differ from the surrounding area.) or uncomplicated Stage II wound (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough, may also present as an intact or open/ruptured serum filled blister). Provide residents with a mattress that meets the criteria for group two if the resident has multiple Stage II wounds or uncomplicated Stage III (full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muscle are not exposed, slough may be present but does not obscure the depth of tissue loss, may include undermining and tunneling) and Stage IV wounds. Provide the resident with a mattress that meets the criteria for group three if the resident has a multiple or complicated Stage IV or unstageable pressure wounds. Group two mattresses include a LAL mattress.<br><br>4. Review of Resident #25's medical record revealed an admission date of 04/18/25 with diagnoses including chronic respiratory failure with ventilator dependence, tracheostomy, gastronomy, traumatic subdural hemorrhage, anxiety, type II diabetes mellitus, chronic congestive heart failure, enterocolitis, cystitis, hypotension, hypotension, neuromuscular bladder, dysphagia, gastroesophageal reflux<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | disease, high blood pressure, multiple fractures of ribs, and fractured neck, and clavicle, thoracic aorta injury, aneurysm of ascending aorta and iliac artery, atrial fibrillation (irregular heart rate), pulmonary embolism and venous thrombosis, and dysphagia.<br><br>A review of Resident #25's record revealed Resident #25 was transferred to the hospital on [DATE] and admitted with diagnoses including septic shock, acute cystitis and atrial fibrillation. Resident #27 returned to the facility on [DATE]. The nursing admission assessment progress note dated 10/27/25 indicated the presence of unstageable pressure ulcers located on the sacrum, right lower leg and ankle.<br><br>A review of Resident #25's nutrition assessment dated [DATE] revealed Resident #25 had dysphagia and was unable to eat orally and tube feeding was implemented. The assessment indicated that Jevity 1.5 solution (high-protein, fiber-fortified liquid formula) was continuously administered via pump at 40 ml per hour with 30 ml water flushes every four hours. Nutritional supplements were not provided. The nutrition assessment revealed Resident #25 did not have a pressure ulcer at the time the assessment was completed.<br><br>Resident #25's nursing progress note dated 10/28/25 indicated pressure ulcers located on the sacrum, and two separate areas on the right lower leg. The sacral pressure ulcer was classified as unstageable measuring 8.0 cm long by 9.8 cm wide by 0.2 cm deep, the right lower calf pressure ulcer measuring 2.0 cm long by 2.0 cm wide by 0.1 cm deep and the right mid-calf pressure ulcer measured 4.0 cm long by 2.5 cm wide by 0.1 cm deep. The progress note indicated Resident #25 would be seen on the next wound rounds.<br><br>A review of the nutrition assessment dated [DATE] revealed a recommendation to increase the Jevity 1.5 tube feeding solution infusion rate to 60 ml per hour.<br><br>A review of the physician order dated 11/19/25 revealed an order to increase the Jevity 1.5 tube feeding solution rate to 60 ml per hour.<br><br>An interview with RD #816 on 12/18/25 at 10:42 A.M. verified the recommendation to the have the tube feeding rate increased was not ordered until 11/19/25. She stated she had sent an email to ADON #350 to inform her of the recommendation and had placed a written document to inform ADON #350 of the request to have Resident #25's tube feeding rate increased. RD #815 verified the above findings during the interview.<br><br>5. A review of Resident #11's medical record revealed an admission date of 10/20/25 with diagnoses including acute duodenal ulcer with perforation, acute kidney failure, acute pulmonary edema, acute respiratory failure with ventilator dependence, anemia, alcohol dependence, candidiasis of skin and nails, cerebral ischemia, cardiac arrest, emphysema, gastroesophageal reflux disease, hypovolemic chock, hypoxic ischemic encephalopathy, idiopathic aseptic necrosis of left femur, pulmonary embolism, pneumonia, sepsis, type II diabetes mellitus, and osteoarthritis. The resident had an unstageable pressure ulcer located on the sacrum on admission.<br><br>A review of Resident #11's nutrition assessment completed on 11/18/25 indicated a recommendation for liquid protein 30 ml daily to promote wound healing.<br><br>A review of Resident #11's physician order dated 12/02/25 to administer 30 ml of liquid protein via gastronomy tube once a day in the morning and to start on 12/03/25.<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A review of Resident #11's medical record revealed the presence of an unstageable pressure ulcer located on the sacrum upon admission [DATE]). The most recent wound assessment dated [DATE] indicated the unstageable sacral pressure ulcer measured 4.0 cm long by 3.0 cm wide by 0.3 cm deep with serosanguinous drainage, yellow slough, and black eschar present. The wound had remained unchanged.<br><br>Interview on 12/17/25 at 11:15 A.M. with Director of Clinical Services #816 revealed a dietitian was to assess a new admission within seven days of admission if a resident was high risk such as a tube feeding, pressure ulcer to see if resident was meeting their estimated needs. The dietitian was to complete the new care plan within 14 days of admission. The dietitian was also expected to assess high risk residents monthly instead of quarterly. The facility Corporate Dietitian #817 provided the consulting dietitian corporate standards for calculations and intervention specific for the facility.<br><br>An interview with RD #816 on 12/18/25 revealed she had recommended a liquid protein supplement be administered to Resident #11 on 11/18/25 and verified the recommendation was not implemented until 12/03/25. RD #816 stated the expectation was the facility should implement the dietician's recommendation within 24 to 48 hours after notification was sent to the facility. RD #816 stated she sent an email to ADON #350 and placed a written notification of the recommendation to add the liquid protein supplement to Resident #11's tube feeding once a day to promote wound healing under ADON #350's door.<br><br>A review of the undated facility's policy titled Pressure Ulcer Prevention, Intervention indicated the purpose of the protocol was to implement preventative skin measures for all residents based on the levels and areas of risk to include moisture, nutrition, activity, mobility, mental status, psychosocial status, and general physical condition. When the Interdisciplinary Team is considering interventions, facility policy, standard of practice, and resident goals/preferences/advanced directives should be reviewed and considered prior to implementation. The residents' skin will be assessed and monitored on a routine basis as is outlined in the skin assessment protocols. Preventative measures will be implemented in accordance with the residents' assessed risk level and for development of skin integrity impairment and risk factors that may enhance the residents' ability to develop skin integrity impairment. Interventions included assessing nutritional risk and address with the Registered Dietician as needed. Maintain or improve nutrition and hydration, when indicated.<br><br>Interventions for nutrition include:<br><br>-Monitor hydration status and increase hydration, as needed.<br><br>-Consult the Registered Dietician, as needed.<br><br>-If the resident who is well-nourished develops an inadequate dietary intake of protein or calories, a nutritional assessment should be completed by the [NAME] to determine the factors compromising the intake. Interventions will be implemented based upon the [NAME] assessment and interdisciplinary team review.<br><br>-It is recommended that when a resident is nutritionally at risk and pressure ulcer risk, the resident is offered a minimum of 30-35 kilocalorie per kilogram (kg) body weight per day, with 1.25-1.5 gram/kg/day protein and 1milliliter (ml of fluid intake per kcal per day).<br><br>-For the residents with nutritional risk and pressure ulcer risk, it is recommended to offer a<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | high-protein mixed oral nutritional supplement and/or tube feeding, in addition to the usual diet.<br><br>-Administer oral nutritional supplements and/or tube feeding in between in regular meals to avoid reduction of normal food and fluid intake during regular mealtimes<br><br>6. Review of the medical record revealed Resident #58 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure with hypoxia, brain stem stroke syndrome, osteomyelitis of vertebra, cervical region, neuromuscular dysfunction of bladder, other seizures, pseudomonas, resistance to vancomycin, local infection of the skin and subcutaneous tissue, klebsiella pneumoniae, extended spectrum beta lactamase, methicillin resistant staphylococcus aureus infection, supraventricular tachycardia, dependence on respirator [ventilator] status, muscle weakness, dysphagia, major depressive disorder, acute embolism and thrombosis of left internal jugular vein, gastrostomy status, generalized anxiety disorder, tracheostomy status, quadriplegia, chronic viral hepatitis c and nonrheumatic mitral (valve) prolapse.<br><br>Review of Resident #58's care plan dated 10/25/25 revealed the resident had impairment of skin integrity due bowel and bladder incontinence, impaired mobility, quadriplegia, activities of daily living (ADL) dependence, altered nutritional status and had pressure injuries to the coccyx and bilateral heels. Interventions included wound treatment as ordered, weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations.<br><br>Review of Resident #58's MDS 3.0 assessment dated [DATE] revealed a BIMS score of 15, indicatin |

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| F 0690<br><br>Level of Harm - Actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of hospital records, interviews and review of facility policy, the facility failed to provide timely care and services to treat Resident #38's urinary tract infection (UTI).Actual harm occurred on 10/13/25 when Resident #38, who had a history of UTI and had been stating she felt like she had UTI symptoms of frequent urination and burning a couple days prior, was ordered a urine analysis (UA) test by Nurse Practitioner (NP) #842 to assess for UTI and that order was not entered into the physician orders until 10/15/25 by Licensed Practical Nurse (LPN) #341. On 10/16/25 Resident #16 was hospitalized prior to completion of the UA test, and Resident #38 was diagnosed at the hospital with altered mental status, acute UTI, bacteremia (bacteria in the blood) and acute kidney injury and was treated with intravenous (IV) antibiotics for the infection. Resident #38 remained in the hospital for treatment until returning to the facility on [DATE] where IV antibiotics were continued for treatment. This affected one resident (Resident #38) of three residents reviewed for urinary tract infections. The facility census was 72.Review of Resident #38's medical record revealed an admission date of 10/06/25 with diagnoses including need for assistance with personal care, neuromuscular dysfunction of bladder, urinary tract infection, tracheostomy, morbid obesity, ventilator dependence, and type two diabetes.Review of Resident #38's progress notes dated 10/13/25 at 2:18 P.M. by Licensed Practical Nurse (LPN) #341 revealed the resident reported she believed she had a UTI stating it started a couple of days ago, but this is the worst it felt. Resident #38 complained of frequent urination and burning. The process of obtaining a UA (urine analysis) was explained to the resident by LPN #321 and the Nurse Practitioner (NP #842) and resident agreed to the UA. A new order was obtained for a UA and labs. Resident #38 did ask if they could treat the UTI without obtaining the UA and the NP stated no and again the resident agreed to the UA.Further review of the medical record revealed there was no UA collected on 10/13/25 for Resident #38. Review of Resident #38's physician orders dated October 2025 revealed the order to obtain a UA C&S (culture and sensitivity) was not entered until 10/15/25 at 5:33 P.M. by LPN #341 and not on 10/13/25 when ordered by NP #842.Review of Resident #38's care plan dated 10/14/25 revealed the resident had bowel and bladder incontinence and was at risk for urinary tract infection (UTI). Interventions included staff to clean peri-area with each incontinence episode, check and change per protocol and as required for incontinence, monitor and document for signs and symptoms of UTI including pain, burning, blood tinged urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. There was nothing in the care plan to indicate Resident #38 refused to have urinalysis tests when needed.Review of Nurse Practitioner (NP) #842's progress note date 10/15/25 revealed Resident #38 was seen again on 10/15/25 for complaints of dysuria (painful or uncomfortable urination) and was agreeable to urinalysis and again ordered a UA. Additionally, under the section of their note titled Assessments and Plans NP #842 noted on 10/13/25 resident complained of dysuria and a UA with culture and sensitivity (UA C&S) was ordered, on 10/14/25 UA C&S was encouraged again, and finally on 10/15/25 UA C&S reordered.Review of the Respiratory Therapist (RT) #364 progress note on 10/15/25 at 6:06 P.M. revealed the RT, two nurses and a Certified Nursing Assistant (CNA) entered the resident's room to obtain the UA. During the process of obtaining the UA, the resident's pulse ox dropped to 69 percent and heart rate dropped to 51. The RT increased the resident's oxygen to 16 liters and a peep (positive end expiratory pressure) of eight and turned the resident's fan on. Resident #38's vital signs improved.Review of LPN #379's progress note dated 10/15/25 at 6:20 P.M. revealed Resident #38 was noted to have altered mental status, an assessment was completed and vital signs were within normal limits, the physician was notified and gave additional orders for a UA to be completed and to continue to monitor.Review of LPN #379's progress note dated 10/16/25 at 7:22<br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A.M. the nurse documented a Change in Condition related to altered mental status, vital signs noted at blood pressure (bp) 152/74, pulse 103, respiratory rate (RR) 28, temperature 98.7 degrees Fahrenheit (F), pulse oxygen 97 percent and was vent dependent, physician was notified and gave orders again to obtain a UA and to send the resident to the emergency room.Review of Resident #38's hospital documentation dated 10/16/25 revealed Resident #38 was sent to the Emergency Department (ED) and admitted for Altered Mental Status (AMS), acute UTI, bacteremia, and acute kidney injury. Resident #38 was treated with broad spectrum antibiotics and was hospitalized from [DATE] to 10/24/25 when they returned to the facility and continued intravenous (IV) antibiotics for UTI.Review of Resident #38's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition. Resident #38 required substantial to maximal assistance with eating and was dependent on staff for all other Activities of Daily Living (ALDs) including incontinence care, showering, dressing, personal hygiene, and bed mobility.An interview on 12/11/25 at 12:37 P.M. with Resident #38 revealed she did not feel staff took her complaints of UTI symptoms seriously in October when she complained of pain, burning and frequent urination. Resident #38 stated she had been telling the nurse for at least two days about the pain in her bladder before the NP came in to see her. Resident #38 stated she had a history of UTIs and knew what they felt like. She stated she had questions about how they would obtain the UA C&S and was agreeable to it, but the facility staff did not get it right away and waited multiple days to get it. Resident #38 stated she continued to complain of pain, burning and frequent urination the whole time. Resident #38 confirmed the NP saw her twice before she went to the hospital. Resident #38 was upset because she ended up in the hospital and felt if they had gotten the UA C&S when first ordered she would not have ended up in the hospital and would not have been as sick as she was.Two attempts were made on 12/11/25 at 1:45 P.M. and on 12/22/25 at 4:05 P.M. to contact NP #842 with no return calls received.Interview on 12/22/25 at 3:40 P.M. with LPN #341 revealed they confirmed Resident #38 complained of burning and frequent urination on 10/13/25 and that the NP was into see the resident and ordered a UA C&S but did not obtain it and did not enter it into the physician orders. LPN #341 Could not give a reason why they did not obtain the UA C&S or why they did not enter it into the physician orders on 10/13/25.Interview on 12/22/25 at 3:52 P.M. with LPN #379 revealed they obtained the UA C&S on 10/15/25 at 6:06 P.M. with the assistance of the RT, another nurse and a CNA. However, they did not send the UA to the lab due to the resident going out to the hospital for altered mental status and that Resident #38 was admitted for a UTI, acute kidney injury and sepsis. When asked why the facility staff did not obtain the UA C&S when originally ordered on 10/13/25 they could not give a reason.An interview on 12/22/25 at 4:15 P.M. with the Director of Nursing (DON) verified Resident #38 was ordered a UA C&S on 10/13/25 by NP #842 which was not entered as an order nor collected from Resident #38 until 10/15/25. The DON confirmed the urine was collected on 10/15/25 and was to be sent out to the lab for testing on the morning of 10/16/25 but when the lab showed Resident #38 had been sent to the hospital that morning, so the urine was not carried through to the lab. Review of facility policy titled Urinary Continence and Incontinence-Assessment and Management last revised September 2024 revealed identification of urinary tract infections will follow relevant clinical guidelines. The policy did not identify the relevant clinical guidelines in the policy.This deficiency represents noncompliance investigated under Complaint Number 2687759. |

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| F 0814<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Dispose of garbage and refuse properly.<br><br>Based on observation, interview and facility policy review, the facility failed to maintain a sanitary garbage storage area. This had the potential to affect all residents. The facility census was 72.Findings include: Observation on 12/10/25 at 8:19 A.M. of the dumpsters revealed one large trash bag torn open and on the ground to the left of the dumpsters. There were two large trash bags on the ground between the two dumpsters with trash including used gloves, straws, and plastic silverware lying on the ground.Interview on 12/10/25 at 8:25 A.M. with the Administrator verified the trash bags and trash on the ground around the dumpster area.Review of the facility policy tilted Food-Related Garbage and Refuse Disposal, dated October 2022, revealed storage areas would be kept clean at all times and would not constitute a nuisance, and outside dumpsters would be free of surrounding litter. |

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| F 0882<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.<br><br>Based on interviews, review of employee personnel files, and review of facility infection surveillance including infection control logs and maps, the facility failed to ensure the Infection Preventionist acquired their Infection Prevention Certificate prior to assuming the role as Infection Preventionist and failed to complete accurate infection control logs and maps. This had the potential to affect all residents in the facility. The facility census was 72.Findings include:Review of the Infection Preventionist (IP) Registered Nurse (RN) #431 employee file revealed a hire date of 06/30/25 with roles indicated as the Infection Preventionist and Wound Care Nurse.<br><br>Review of IP RN #431's Infection Preventionist certificate revealed they received their certificate on 08/30/25.<br><br>Review of the facility infection control logs and surveillance map dated October 2025 revealed Resident #25's Clostridium Difficile (C-diff) infection dated 10/14/25 was not documented on either the log or map.<br><br>Review of the facility infection control logs and surveillance map dated November 2025 revealed Resident #64's C-diff infection dated 11/26/25, and Resident #62's Candida Auris infection dated 11/16/25, and urinary tract infection (UTI) dated 11/27/25 were not documented on either the log or map.<br><br>An interview on 12/30/25 at 4:30 P.M. with IP RN #431 revealed she was hired at the facility with a start date of 06/30/25 as the Infection Preventionist and Wound Care Nurse. IP RN #431 stated she completed the Infection Preventionist Training Course from 08/24/25 to 08/30/25, received the certificate on 08/30/25 and had no previous formal training on infection prevention prior to this date. IP RN #431 stated the previous Infection Preventionist (RN #340) trained her for two weeks then took a position on the floor and had no further oversite as of 07/21/25. IP RN #431 stated her training was watching RN #340 for one week, then for the second week completing the tasks she watched RN #340 complete the week prior. When asked where the December 2025 infection control log and surveillance was map, she stated it was incomplete and would not be ready for review until 01/01/26. When asked why, she stated she did not keep a running log of infections for the month because she waited until the end of the month to compile the data and completed the surveillance maps. IP RN #431 confirmed the infection control logs from October 2025, and November 2025 were incomplete and did not have all the infections for the facility listed on them including infections for Residents #25, #62 and #64.<br><br>The December 2025 infection control log was not made available to the surveyor for review until 12/31/25 at 2:00 P.M when IP RN #431 provided it to the survey team. IP RN #431 did not provide a surveillance map for review for December 2025.<br><br>An interview on 12/31/25 at 11:10 A.M. with the Infectious Disease (ID) Physician #809 revealed he stated the facility had a severe problem with infection control at the facility related to the number of severe opportunistic infection rates.<br><br>An interview on 12/31/25 at 11:15 A.M. with RN #340 revealed she personally did not review any infection logs, maps, or documents related to the Infection Preventionist roll since she took a position on the floor as of 07/21/25.<br>(continued on next page) |

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| F 0882<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of the facility policy titled Policies and Practices-Infection Control, last revised October 2018, revealed the objectives of the infection control policies were to:<br><br>Prevent, detect, investigate, and control infections in the facility<br><br>Establish guidelines for implementing isolation precautions, including Transmission-based precautions<br><br>Review of the facility policy titled Antibiotic Stewardship-Review and Surveillance of Antibiotic Use and Outcomes, last revised July 2025, revealed as part of the facility Antibiotic stewardship program all clinical infections treated with antibiotics will undergo review by the Infection Preventionist or designee and be documented on facility approved surveillance tracking forms.<br><br>This deficient practice represents noncompliance investigated under Complaint Number 2655919. |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interviews and review of facility policy, the facility failed to maintain a safe, functional, sanitary and comfortable environment. This had the potential to affect all 72 residents.Findings include:An observation on 11/20/25 at 1:20 P.M. with Maintenance Supervisor (MS) #368 revealed a large ceiling stain near resident room [ROOM NUMBER] on the Aspen unit. Interview with MS #368 at the time of the observation revealed the stain was from a roof leak about a month ago. When asked if water got inside the air duct work he stated yes, and stated the facility had a company come replace the duct work. Continued observation at 1:22 P.M. with MS #368 inside of room [ROOM NUMBER] revealed a large amount of lint and signs of mold in the ceiling vent. MS #368 verified the findings at the time of the observation. An observation was conducted on 11/20/25 at 1:24 P.M. of the attic on the even room number side of the Aspen unit to inspect the stained area. Observation revealed duct work was not replaced, a plastic drain pipe was disconnected, wet insulation removed from the duct work was left in the area, and signs of what appeared to be water stains and mold on drywall. Observation also revealed a decomposed rodent resembling an opossum outside of room [ROOM NUMBER] in the ceiling. Photographs were taken at the time of the observation by the life safety surveyor and verified by MS #368. MS #368 stated the air flow from the attic ran into room [ROOM NUMBER]. Observations were conducted on 11/24/25 with MS #368 of the Aspen unit and Crabapple unit revealing on the Aspen unit two holes had been drilled through the ceiling wooden sofit into the attic and on the Crabapple unit two holes had been drilled through the ceiling wooden sofit into the attic. All of the holes presented as drain holes from the attic floor out to the air of each unit. MS #368 verified the finding at the time of the observation.Observation on 11/25/25 at 10:05 A.M. with the Administrator of the Somerset Unit revealed tile had fallen off the wall exposing a black substance in the grout in the Somerset utility room. There was standing water in the utility sink with black biofilm around the perimeter of the utility tub, and there was a pervasive musty smell in the hall of the unit. Also in the utility room, a vent fan had a build-up of black substance in the vent fan. The findings were verified by the Administrator at the time of the observation. Interview on 11/26/25 at 11:44 A.M. with Respiratory Therapist #364 revealed she heard a rodent, estimated for the last month, in the attic and informed administration. Observation on 11/26/25 at 12:27 P.M. of room [ROOM NUMBER] bathroom revealed a plastic wash basin was underneath the bathroom sink with water leaking from the sink. Licensed Practical Nurse (LPN) #319 was present during the observation and confirmed the finding. An interview on 11/26/25 at 2:20 P.M. with Respiratory Therapist (RT) #364 revealed in July 2025 there was a leak in the ceiling outside in the 500 hallway outside of room [ROOM NUMBER]. RT #364 said water was dripping down from the ceiling and buckets were placed in the hallway to catch the water that was dripping onto the floor. RT #364 reported that the ceiling was painted over on 11/23/25 to cover up the water stains. An observation on 12/01/25 at 9:03 A.M. of the facility in-house dialysis unit revealed there were multiple broken pieces of flooring in the hallway upon entrance into the dialysis unit by the door. Dialysis RN #841 revealed the facility was responsibile for upkeep of the physical repairs of the unit and had been waiting on the contractor to come back and fix the floor.An interview with the Administrator on 12/01/25 at 9:20 A.M. revealed the facility had been trying to reach out to the floor contractor but had not been able to reach them. The Administrator stated she was unable to provide any documented evidence of attempts to contact the contractor for repairs. Observation on 12/08/25 at 9:40 A.M. through 10:12 A.M. with MS #368 revealed evidence of animal nests in the facility attic. MS #368 verified the finding at the time of the observation. Observation on 12/08/25 at 10:57 A.M. with MS #368 revealed the first floor office of the facilitys' Infection Preventionist had a ceiling with over half the ceiling heavily covered in dark brown staining indicative of water infiltration from prior<br>(continued on next page) |

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|---|---|---|---|
| | 365539 | A. Building<br>B. Wing | 12/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Warren Nursing & Rehab | 2473 North Rd NE<br>Warren, OH 44483 |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | roof leaks. The staining went from the perimeter of the bricked wall, to the window and to the center of the ceiling where the ceiling light was mounted. An observation was conducted on 12/09/25 at 11:55 A.M. upon entering the facility dialysis unit revealed 17 chipped and cracked gray floor panels measuring approximately 30 inches long by five inches wide each were either lifting around the edges and/or ends or had large missing pieces exposing subfloor. The dialysis unit also had a foul, biological-waste odor consistent with drain back-up.An interview on 12/09/25 at 12:03 P.M. with Dialysis RN #841 verified the chipped and cracked floor panels and revealed the floor panels were never installed correctly since installed and after the flood back in June the tiles lifting and cracking from the floor got worse. RN #841 revealed she was concerned of it being a trip hazard, has been asking for months for it to get fixed and it has still not been fixed. RN #841 stated the flood water was in the common area out side of dialysis and was several inches deep and it flowed in under the entry door to dialysis which afffected those tiles. RN #841 also stated the foul odor on the unit was the resident body waste that was going into the drains from the multiple dialysis machines which went under the floors to the outside. RN #841 said a company had come out several times to clean the drains but the odor will not go away. RN #841 stated a dialysis unit should not have an odor of body waste. Interview on 12/11/25 at 12:11 P.M. with Restoration Contractor (RC) #845 revealed his company provided the water mitigation after the facility flooded in June 2025. RC #845 revealed he spoke with the facility about the flooring in the dialysis unit after the flood and that water had gone underneath the floor in the dialysis unit. RC #845 stated he recommended the facility close the dialysis unit to properly restore the unit and the facility told him they could not close the unit. RC #845 stated the facility told him that a flooring company would be coming the following Monday to replace the floor.Observation on 12/15/25 at 10:26 A.M. revealed the bottom half of room [ROOM NUMBER] entrance door was covered by thin plastic door protector than had separated from the door and was hanging loose exposing a sharp corner sticking out into the doorway entrance. Inside the room hung a privacy curtain separating the two beds in the room. On the privacy curtain was an approximate three feet by two feet area of dark purplish brown staining of either dried blood or feces. Certified Nurse Assistant (CNA) #404 was present during the observation and verified the findings. CNA #404 stated the plastic door protector kept coming off because the resident's wheelchairs get stuck on the door cover going in and out of the room. CNA #404 verified a resident could get injured on the loose sharp corner of the plastic door protector hanging off the door. Observation on 12/18/2025 at 11:41 A.M. of room [ROOM NUMBER] revealed the plastic door protector was now attached to the door with duct tape and the privacy curtain was cleaned and replaced.Observation and interview on 12/29/2025 at 2:47 P.M. with Unit Manager (UM) #846 of room [ROOM NUMBER] door protector revealed the duct tape had come unstuck and the door protector was not attached to the door. UM#846 stated she would put in another work order.Observation on 12/31/2025 at 11:08 A.M. of room [ROOM NUMBER] door protector revealed the door protector was now secured to the door with screws.Review of facility policy titled Quality of Life Homelike Environment, date revised May 2017, revealed facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include a clean, sanitary and orderly environment.This deficiency represents non-compliance investigated under Complaint Numbers 2683142, 2687759, 2674189, 2684242, and 2688137. |

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| F 0942<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents.<br><br>Based on personnel record review, interview and document review, the facility failed to ensure complete orientation of 14 newly hired Certified Nursing Assistants. This had the potential to affect all residents residing in the facility. The facility census was 72.Findings include:On 12/18/25 at 2:33 P.M. a review of personnel files was conducted with Human Resource Director (HRD) #443.A review of the personnel file for Certified Nurse Assistant (CNA) #436 revealed a date of hire (DOH) of 09/09/25. There was no completed clinical nursing assistant orientation form within the personnel file.A review of the personnel file for CNA #450 revealed a DOH of 10/23/25. There was no completed clinical nursing assistant orientation form within the personnel file.A review of the personnel file for CNA #440 revealed a DOH of 09/18/25. There was no completed clinical nursing assistant orientation form within the personnel file.A review of the personnel file for CNA #439 revealed a DOH of 09/09/25. There was no completed clinical nursing assistant orientation form within the personnel file.A review of the personnel file for CNA #457 revealed a DOH of 11/11/25. There was no completed clinical nursing assistant orientation form within the personnel file.A review of the personnel file for CNA #437 revealed a DOH of 09/02/25. There was no completed clinical nursing assistant orientation form within the personnel file.A review of the personnel file for CNA #438 revealed a DOH of 09/02/25. There was no completed clinical nursing assistant orientation form within the personnel file.A review of the personnel file for CNA #453 revealed a DOH of 11/11/25. There was no completed clinical nursing assistant orientation form within the personnel file.A review of the personnel file for CNA #455 revealed a DOH of 11/11/25. There was no completed clinical nursing assistant orientation form within the personnel file.A review of the personnel file for CNA #454 revealed a DOH of 11/11/25. There was no completed clinical nursing assistant orientation form within the personnel file.A review of the personnel file for CNA #408 revealed a DOH of 02/25/25. There was no completed clinical nursing assistant orientation form within the personnel file.A review of the personnel file for CNA #411 revealed a DOH of 06/10/25. There was no completed clinical nursing assistant orientation form within the personnel file.A review of the personnel file for CNA #416 revealed a DOH of 04/01/25. There was no completed clinical nursing assistant orientation form within the personnel file.A review of the personnel file for CNA #388 revealed a DOH of 05/05/25. There was no completed clinical nursing assistant orientation form within the personnel file.HRD #443 verified the lack of clinical nursing assistant orientation forms in the personnel files for CNAs #436, #450, #440, #439, #457, #437, #438, #453, #455, #454, #408, #411, #416, #388 at the time of the personnel file reviews.A review of the document titled Job Description: State Tested Nursing Assistant updated May 2025 revealed The CNA is responsible for the delivery of nursing care to residents, monitoring their stability and well-being. The document further stated that the CNA is responsible for demonstrating knowledge and adhering to all Residents Rights.A review of the undated document titled New Employee Orientation Agenda - Day 2 (STNA ONLY) revealed an expectation that the orientation checklist must be returned to the Staff Development Coordinator before taking an individual assignment. |

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| Warren Nursing & Rehab | 2473 North Rd NE<br>Warren, OH 44483 |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>Based on observation, interviews, record review, and review of maintenance documents and facility policy, the facility failed to maintain adequate room temperatures in the common area/dining room and resident rooms. This affected six residents (#15, #34, #48, #50, #52 and #69), and had the potential to affect 26 residents (#5, #6, #7, #8, #16, #23, #24, #26, #32, #36, #39, #43, #46, #47, #48, #51, #53, #56, #57, #59, #60, #66, #68, #69, #70 and #93) who used the common area/dining room . The facility census was 72.Findings include:Interview on 11/26/25 at 8:10 A.M. with Resident #15 complained the common area was so cold last week he had to stay in his room because his room was warmer.Interview on 11/26/25 at 8:15 A.M. with Certified Nurse Assistant (CNA) #840 stated the building was so cold last week, the residents refused to receive showers.Interview on 11/26/25 at 8:25 A.M. with Resident #48 complained the common area was so cold he had to eat lunch in his room and did not like to feel that cold.Interview on 11/26/25 at 8:26 A.M. with Registered Nurse (RN) #431 verified Resident #48 preferred to eat in the common area and liked to be out of his room to participate with others.Interview on 11/26/25 at 9:04 A.M. with Regional Director of Operations (RDO) #802 revealed nursing staff had contacted him because the thermostat read 67 degrees Fahrenheit (F).Observation on 12/01/25 at 9:25 A.M. of the second-floor common area revealed the thermostat read 68 degrees (F) and the air handler which conditions and circulates air read 64 degrees (F). Interview with Housekeeper #331 at the time of the observation verified the temperature readings and stated no staff were able to change the thermostats in the common area/dining room. The prior weekend was so cold in the facility, she had to wear extra clothing and complained how cold the facility was over the holiday weekend.Interview on 12/01/25 at 9:30 A.M. with Resident #50 who was sitting in the second-floor dining room with a blanket on complained the dining room was too cold to be comfortable.Interview on 12/01/25 at 9:40 A.M. with Resident #52 complained that over the prior weekend her room was so cold she had to sleep with three blankets on.Interview on 12/01/25 at 3:14 P.M. with Maintenance Supervisor (MS) #368 verified the upstairs dining room/common area was cold in the mornings. He stated the air handler needed reset.Observation on 12/02/25 from 9:30 A.M. to 10:11 A.M. with RDO #802 of room temperatures using the facility's handheld digital thermometer which tests ambient air temperatures revealed Resident #69's room was at 69 degrees (F). Interview at the time of the observation with RDO #802 verified the finding, and stated the facility was heated by a roof top unit that blew into each resident's room.Observation on 12/16/25 at 9:35 A.M. during medication pass observation of Resident #34's room who complained the room was always cold revealed an unnamed maintenance staff member took an ambient temperature using a handheld digital thermometer which resulted in a reading of Resident #34's room as 67 degrees (F), then repeated was 66.9 degrees (F), and finally was 67.3 degrees (F). Resident #34 was provided with an additional blanket.Interview on 12/16/25 at 11:00 A.M. with the Administrator verified the heat was out in the building and was notified at 5 A.M. on that day (not specified). The Administrator stated maintenance came in that morning and discovered a breaker was down.Review of a maintenance document from a heating company dated 11/09/25 revealed the heat exchanger needed replaced, and it was recommended a new inducer and burners be replaced.Review of a maintenance document from a heating company dated 11/20/25 revealed all heating units on-site seemed to operate with incorrect gas pressure settings. The gas pressure was adjusted on the three units that were part of the scheduled service, but the remaining units on-site still required gas pressure adjustments, and must be set up to ensure proper combustion, efficient heating performance, and compliance with equipment standards.Review of the facility policy entitled, Temperature Extremes, dated February 2025 revealed the temperature throughout the facility would be maintained between 71 and 81 degrees (F). Any temperature outside of the range required specific interventions to avoid potential negative impact on the residents' well-being.This deficiency represents non-compliance investigated under Complaint<br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Number 2687759, Complaint Number 2674189, Complaint Number 2684242, Complaint Number 2679591, Complaint Number 2688137, Complaint Number 2672693, Complaint Number 2647699 and Complaint Number 2614520. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure nutritional recommendations were implemented in a timely manner for Residents #11, #21, and #25. Additionally, the facility failed to meet estimated energy needs for Resident #2 who was dependent on enteral (tube) feeding for nutrition. Additionally, the facility failed to evaluate Resident #33 (who was identified to be a high nutritional risk) on a monthly basis. The facility identified 15 current residents who required enteral feeding. This affected five residents (#2, #11, #21, #25, and #33) of 13 residents reviewed for nutrition. The facility census was 72. Findings include: 1. Review of Resident #25's medical record revealed an admission date of 04/18/25 with diagnoses including chronic respiratory failure with ventilator dependence, tracheostomy, gastrostomy status, traumatic subdural hemorrhage, anxiety, type 2 diabetes mellitus, chronic congestive heart failure, enterocolitis, cystitis, hypotension, hypotension, neuromuscular bladder, dysphagia, gastroesophageal reflux disease, high blood pressure, multiple fractures of ribs, and fractured neck, and clavicle, thoracic aorta injury, aneurysm of ascending aorta and iliac artery, atrial fibrillation (irregular heart rate), pulmonary embolism and venous thrombosis, and dysphagia.<br><br>Review of Resident #25's clinical record revealed Resident #25 was sent to the hospital on [DATE] and admitted with diagnoses including septic shock, acute cystitis and atrial fibrillation. Resident #27 returned to the facility on [DATE]. The nursing admission assessment progress note dated 10/27/25 indicated the presence of unstageable pressure ulcers located on the sacrum, right lower leg and ankle.<br><br>Review of Resident #25's nutrition assessment dated [DATE] revealed Resident #25 had dysphagia, was unable to eat orally, and tube feedings were implemented. The assessment indicated that Jevity 1.5 cal (tube feeding solution indicating 1.5 calories is provided per milliliter) solution was continuously administered via an enteral feeding pump at 40 milliliters (ml) per hour with 30 ml water flushes every four hours. The assessment indicated additional nutritional supplements were not provided. The nutrition assessment revealed Resident #25 did not have a pressure ulcer at the time the assessment was completed.<br><br>A review of the nutrition assessment dated [DATE] revealed a recommendation to increase the Jevity 1.5 cal tube feeding solution infusion rate to 60 ml per hour.<br><br>A review of the physician order dated 11/19/25 revealed an order to increase the Jevity 1.5 tube feeding solution rate to 60 ml per hour.<br><br>An interview with Registered Dietitian (RD) #816 on 12/18/25 at 10:42 A.M. verified the recommendation to the have Resident #25's tube feeding rate increased was not ordered until 11/19/25. RD #816 stated she had sent an email to Assistant Director of Nursing (ADON) #350 to inform her of the recommendation and had placed a written document to inform the ADON #350 of the request to have Resident #25's tube feeding rate increased. RD #816 verified the above findings during the interview.<br><br>2. Review of Resident #11's clinical record revealed an admission date of 10/20/25 with diagnoses including acute duodenal ulcer with perforation, acute kidney failure, acute pulmonary edema, acute respiratory failure with ventilator dependence, anemia, alcohol dependence, candidiasis of skin and nails, cerebral ischemia, cardiac arrest, emphysema, gastroesophageal reflux disease, hypovolemic (continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | chock, hypoxic ischemic encephalopathy, idiopathic aseptic necrosis of left femur, pulmonary embolism, pneumonia, sepsis, type 2 diabetes mellitus, and osteoarthritis.<br><br>Review of Resident #11's nutrition assessment completed on 11/18/25 indicated a recommendation for liquid protein supplement 30 ml daily to promote wound healing.<br><br>Review of Resident #11's physician order dated 12/02/25 stated to administer 30 ml of liquid protein via gastrostomy tube once a day in the morning and would start on 12/03/25.<br><br>Interview on 12/17/25 at 11:15 A.M. with RD #816 revealed a dietitian was to assess a new admission within seven days of admission if a resident was high risk, such as if a resident required tube feeding or had a pressure ulcer, to see if the resident was meeting their estimated needs. The dietitian was to complete the new care plan within 14 days of admission. The dietitian was also expected to assess high risk residents on a monthly basis instead of quarterly. The facility's Corporate Dietitian #817 provided the consulting dietitian corporate standards for calculations and intervention specific for the facility.<br><br>An interview with RD #816 on 12/18/25 revealed she had recommended a liquid protein supplement be administered to Resident #11 on 11/18/25 and verified the recommendation was not implemented until 12/03/25. RD #816 stated the expectation was the facility should implement the dietitian's recommendation within 24 to 48 hours after notification was sent to the facility. RD #816 stated she sent an email to ADON #350 and placed a written notification of the recommendation to add the liquid protein supplement to Resident #11's tube feeding once a day to promote wound healing under the ADON #350's door.<br><br>3. Resident #2 was admitted to the facility on [DATE]. Medical diagnoses included chronic respiratory failure, dependence on ventilator, muscle weakness, difficulty swallowing, end stage renal disease, dependence of renal dialysis, tracheostomy, gastrostomy status, and nutritional deficiency. Resident #2 was noted to weigh 122.8 pounds (lbs) upon admission to the facility on [DATE].<br><br>Review of the Minimum Data Set (MDS) 3.0 admission assessment dated [DATE] revealed Resident #2 had severely impaired cognition with a Brief Interview of Mental Status score of 07. Resident #2 did not reject care and did not attempt to eat. Resident #2 was dependent on staff to transfer from bed to chair. Resident #2 required enteral feeds which provided 51 percent (%)or more of the total daily calories. Resident #2 was on oxygen therapy, suctioning, tracheostomy care, invasive mechanical ventilator, and dialysis.<br><br>Review of the plan of care dated 12/05/25, revealed Resident #2 required a tube feeding related to difficulty swallowing, other nutrition risk included end stage renal disease with dialysis thus needing Nepro tube feeding, wound care , and undesired significant weight loss. The goal was for Resident #2 to maintain a stable weight. Interventions included collaborating with the dialysis dietitian, monitor for tube dislodgement, obtain labs, dietitian to evaluate quarterly and as needed, monitor calorie intake, estimated needs, and make recommendations for changes to tube feeding as needed,<br><br>Review of the admission Nutrition assessment dated [DATE] at 8:35 P.M. written by Dietitian #820 revealed Resident #2 was assessed for pressure ulcer, enteral feedings, and dialysis. Resident #2 received no food by mouth. The goal was to have a stable current weight. Resident #2 was ordered Nepro at 35 ml per hour for 20 hours daily to provide 1260 calories and 56 grams of protein. Estimated energy needs consisted of 1500 to 1700 calories and about 55 grams of protein. Resident #2 was<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | noted to have an Unstageable coccyx wound on admission. ProSource protein supplement was added daily and a recommendation to run Nepro continuous (24 hours per day) at 35 ml per hour to provide 1512 calories and 68 grams protein was made.<br><br>Review of a weight change note dated 11/18/25 written by Dietitian #820 revealed Resident #2 was at risk for malnutrition as evidenced by current body weight on 11/17/25 was 114.8 pounds. The comparison weight was 122.6 pounds on 11/13/25 which indicated a 6.4% weight loss in four days. The note indicated Resident #2's tube feeding was adjusted to meet estimated energy needs.<br><br>Review of the physician order start date of 11/18/25 end date of 12/05/25 revealed Resident #2 was to receive enteral feeding with Nepro at 40 ml per hour for 20 hours.<br><br>Review of Dietary Note dated 12/04/25 written by Dietitian #820 revealed Resident #2 was on Nepro at 40 ml per hour to provide 1620 calories and 73 grams protein. ProSource protein supplement was provided for altered skin. Resident #2 had high estimated energy needs due to weight loss and wound care. Nepro provided the estimated energy needs per order on 11/18/25.<br><br>Review of a weight change note dated 12/05/25 written by Dietitian #820 revealed Resident #2 had a 5.7 % weight loss in one month and a 6.6 % weight loss in 18 days.<br><br>Review of physician orders dated 12/05/25 revealed Resident #2's enteral feed order was increased to Nepro at 45 ml per hour for 20 hours per day.<br><br>Review of Resident #2's weights revealed on 12/05/25 the resident weighed 108.2 pounds.<br><br>Review of facility document titled Wounds for 12/01/25 to 12/17/25 revealed on 12/03/25 Resident #2 had an unstageable pressure ulcer on the coccyx and on 12/10/25 the unstageable coccyx pressure ulcer was resolved.<br><br>Observation on 12/22/25 at 3:30 P.M. revealed Resident #2 was in her reclining chair adjacent to her bed in her room. Inspection of the tube feeding setup revealed the feeding pump was not powered on, the tube feeding monitor display was not lit, there was no display of rate, volume, or status indicators to indicate the tube feeding pump was in use. There were no audible alarms or alerts present at the time of observation.<br><br>Observation for 12/22/25 at 3:45 P.M. with Licensed Practical Nurse (LPN) #424 verified the tubing connection and flow was not on by a manual check of the feeding pump and stated the tube feeding had not been restarted since Resident #2 came back from dialysis at noon. LPN #424 stated Resident #2 had dialysis earlier in the day and does not receive enteral feeding during dialysis treatments.<br><br>Interview on 12/23/25 at 10:14 A.M. with Dietitian #820 revealed Nepro at 45 ml per hour was needed to meet the resident's estimated energy needs. Based on the resident's nutrition assessment on 11/18/25, Resident #2 was at risk for malnutrition, therefore the tube feeding rate was increased because the original rate was not meeting the resident's estimated energy needs and had resulted in Resident #2 having a weight loss. Dietitian #820 stated the facility did not notify her of significant weight changes or which resident needed monitored. If a resident had a significant weight change, Dietitian #820 would notify ADON #350. ADON #350 then was to notify the DON if there was a significant weight change. If there was a significant weight change, the facility was expected to reweigh the resident. Dietitian #820 stated she did not attend risk meetings regarding weight changes<br>(continued on next page) |

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| | 365539 | A. Building<br>B. Wing | 12/31/2025 |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | in the facility.<br><br>4. Resident #21 was admitted to the facility on [DATE]. Medical diagnosis included sepsis (systemic infection), moderate protein calorie malnutrition, urinary tract infection, end stage renal disease needing dialysis, diabetes, encephalopathy (disorder of the brain) acute respiratory failure, cerebral infarction, dependence on renal dialysis and dysphagia (difficulty swallowing).<br><br>Review of Resident #21's physician orders revealed an order dated 08/08/25 for Vital Advanced Formula (AF), an enteral feeding solution. Vital AF was to be administered at a rate of 45 ml per hour for a duration of 20 hours daily.<br><br>Review of an admission Nutrition assessment dated [DATE] at 4:47 P.M. authored by Dietitian #819 revealed Resident #21 needed enteral feeding and dialysis. Resident #21 was ordered to have nothing by mouth and the majority of nutrition was through tube feedings. The goal was for Resident #21 to maintain a stable weight and ensure estimated energy needs consisting of 1682 calories and 67 grams of protein were provided. Resident #21 had an existing diagnosis of protein calorie malnutrition. Current tube feeding order was Vital AF at 45 ml per hour that provided 1296 calories and 81 grams of protein. Dietitian #819 was to follow weight and tube feeding acceptance because the ordered tube feeding was less than calculated estimated nutrition needs.<br><br>Review of Resident #21's weights revealed on 09/02/25, the resident weighed 143.9 pounds.<br><br>Review of the MDS 3.0 quarterly assessment dated [DATE] revealed Resident #21 had a BIMS score of 8 indicating moderately impaired cognition. Resident #21 did not display physical or verbal behaviors and did not reject care. Resident #21 did not attempt to eat, was dependent on activities of daily living (ADLs). Resident #21 required extensive assistance to roll left and right in bed and to sit on the side of the bed. Resident #21 was dependent on staff to stand, and transfer from bed to chair. Resident #21 needed a feeding tube for nutrition that provided 51% or more of total calories and 501 cubic centimeters (equivalent to milliliters) of fluids per day. Resident #21 additionally required dialysis treatments.<br><br>Continued review of Resident #21's weights revealed on 11/05/25 the resident weighed 140.8 pounds. Review of the plan of care dated 12/03/25 revealed Resident #21 had the potential for alteration in nutrition and hydration related to sepsis, encephalopathy, gastroenteritis, cerebral infarction, type two diabetes, dysphagia, end stage renal disease with hemodialysis, nothing by mouth need for tube feeding. Goal was no significant weight change with edema, demonstrate adequate hydration, and tolerate dialysis treatments. Interventions included administer medication, collaborate with dialysis dietitian on plan of care, dialysis treatments per order, monitor dialysis site for bleeding, monitor for dehydration, monitor for fluid overload and notify physician, monitor of difficulty swallowing, monitor of signs and symptoms of malnutrition such as muscle wasting, significant weight loss, obtain labs and monitor, provide nothing by mouth. Review of Resident #21's weights revealed on 12/05/25, the resident weighed 124.1 pounds. On 12/18/25, Resident #21 weighed 124.7 pounds. Review of a weight change note dated 12/05/25 at 10:19 P.M. written by Dietitian #820 revealed Resident #21 had a one- and three-month weight loss. Current tube feeding order of Vital AF at 45 ml per hour for 20 hours provided 1080 calories, and 67.5 grams protein. Resident #21 had an 11.86 percent weight loss in one month and 13.76 weight loss in three months. Due to the weight loss, the RD requested to increase Vital AF tube feeding to 65 ml per hour for 20 hours to provide 1300 calories, and 97 grams of protein.<br><br>Review of a dietary note dated 12/20/25 written by Dietitian #820 revealed Resident #21 was out of<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | the facility from 12/15/25 to 12/17/25. Current tube feeding order was Vital AF at 45 ml per hour for 20 hours. Dietitian #820 requested a reweight. Resident #21's estimated calorie needs were 1500 calories and 56 grams of protein. The resident's tube feeding of Vital AF at 45 ml per hour was providing 1080 calories and 67.5 grams of protein. Dietitian #820 requested Vital AF to increase to 65 ml per hour for 20 hours.<br><br>Review of physician orders start dated 12/20/25 revealed Resident #21 had an enteral feed order for Vital AF at 65 ml per hour for 20 hours per day.<br><br>Interview on 12/18/25 at 12:25 with ADON #350 revealed all reweighs of a resident were done immediately if a significant weight change occurred. The reweight was documented in the electronic medical record. She stated the facility did not have a risk meeting regarding weights since October 2025 when the previous Director of Nursing quit.<br><br>Interview on 12/23/25 at 10:14 A.M. with Dietitian #820 verified a request was made on 12/05/25 to increase Resident #21's tube feeding rate, but was not implemented until 12/20/25 when a second request was made. Dietitian #820 verified Resident #21 had a significant weight loss because the original tube feeding rate did not meet the resident's estimated energy needs. Dietitian #820 stated it was not protocol for the dietitian to call the physician regarding nutrition recommendations, but ADON #350 was notified by email of nutrition recommendations and was to make the request to the physician and then write the order. Dietitian #820 verified she made a recommendation on 12/05/25 for the tube feeding rate to be increased but the rate was not increased until 12/20/25 per physician orders, 15 days later. Dietitian #820 also verified Resident #21 was not care planned to be on a weight loss program.<br><br>Interview on 12/23/25 at 4:00 P.M. with ADON #350 revealed she received Dietitian #820's email requesting Resident #21's tube feeding rate to be increased but assumed Dietitian #820 was to call the physician for approval and notify the family of the order change.<br><br>Interview on 12/24/25 at 12:30 P.M. with the Director of Nursing verified the facility did not have weight or risk meetings since she started and assumed the dietitian was to call the physician and family regarding order changes because that was done in her previous facility.<br><br>Interview on 12/24/25 at 12:31 P.M. with The Administrator revealed the facility had not approached the Medical Director if Dietitian #820 could have order writing privileges in the facility.<br><br>Interview on 12/30/25 at 10:56 A.M. with Corporate Dietitian #817 revealed the dietitian or nurse could notify the physician to increase the tube feeding rate. If the dietitian contacted the physician the dietitian was to communicate with nursing staff. The current dietitian in the facility did not have order writing privileges.<br><br>The facility was not able to produce a policy and procedure regarding nutrition recommendations and Dietitian order writing privileges.<br><br>5. Resident #33 was admitted to the facility on [DATE]. Medical diagnosis included end stage renal disease, congestive heart failure, type two diabetes, absence of left knee, morbid obesity, and dependence on dialysis.<br><br>Review of physician orders start date 04/07/23 revealed the facility was to monitor Resident #33's<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | weight monthly and an order dated 10/01/24 for a regular diet with an 1800 ml daily fluid restriction.<br><br>Review of Nutrition Plan of Care revision date 10/09/24 written by Facility Corporate Dietitian #817 revealed Resident #33 had nutrition problems related to end stage renal disease on dialysis, history of swallowing difficulties, history of significant weight fluctuations, body mass index above desired range and fluid restriction. Goal was to have nutritionally pertinent labs. Interventions included administer medication, collaborate with Dialyze direct dietitian on plan of care. Resident was on dialysis but on a therapeutic renal diet restrictions based on labs. Diet recommendations as needed, fluid restriction per physician order, night snack, monitor weights, monitor for signs of dysphagia, obtain labs as ordered, provide diet as ordered, monitor intake, and the facility dietitian was to evaluate and make diet change recommendations.<br><br>Review of Resident #33's nutritional assessments revealed an annual assessment was completed on 10/22/24, and the next nutrition assessment was completed 12 months later on 10/22/25.<br><br>Continued review of Resident #33's electronic medical record revealed a monthly nutrition note was documented on 02/21/25, 03/19/25, 04/11/25, 05/19/25, 05/28/25 and 07/21/25. No monthly nutrition note was documented again until 10/14/25 when the quarterly nutrition assessment was due, followed by monthly nutrition notes on 11/09/25, and 12/04/25.<br><br>Review of the MDS 3.0 Discharge Assessment Return Anticipated dated 10/13/25 revealed Resident #33 short- and long-term memory was okay. Resident #33 did not reject care and needed assistance for eating, maximal assistance for oral hygiene. Resident #33 was dependent on staff to roll left and right in bed, and transfer from the bed to a chair. Resident #33 was on a therapeutic diet and received dialysis.<br><br>Review of facility census records revealed Resident #33 was actively admitted in the facility until 10/13/25 when Resident #33 was admitted to a local hospital. Resident #33 returned to the facility on [DATE].<br><br>Review of Resident #33's recorded weights revealed on 11/05/25 the resident weighed 278.0 pounds and on 12/04/25 the resident weighed 250.0 pounds. Review of a weight change note dated 12/04/25 written by Dietitian #820 revealed weight loss was desired, intake was ok, and the resident tolerated their ordered diet.<br><br>Interview on 12/17/25 at 9:36 A.M. with RD #816 revealed dietitians were to evaluate residents who were deemed high risk, such as residents who required dialysis or tube feedings, on a monthly basis instead of quarterly.<br><br>Interview on 12/17/25 at 1:59 P.M. with MDS Nurse #418 revealed the dietitian had access to update nutrition plan of cares and was expected to update nutrition plan of care if a new intervention or goal was put in place.<br><br>Interview on 12/23/25 at 10:14 A.M. with Dietitian #820 revealed Resident #33 was considered a high nutrition risk resident because he received hemodialysis and recommended to follow Resident #33's nutrition status monthly instead of quarterly. Dietitian #820 verified Resident #33 had a significant weight loss and was not care planned to be on a weight loss program. Dietitian #820 stated all residents were to be weighed monthly. Dietitian #820 also verified Resident #33 was not assessed by a dietitian or had a nutrition note between 07/21/25 and 10/14/25.<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on 12/30/25 at 10:08 A.M. with Facility Corporate Dietitian #817 verified that a dietitian did not assess Resident #33 or have a nutrition note from the dates of 07/21/25 to 10/14/25 and Resident #33 was not care planned to be on a weight loss program. Review of facility policy Weight Management Guidelines undated, revealed weights should be recorded in the medical record by a qualified nutrition professional. If a weight loss was clinically desired from usual body weight range a care plan should reflect this. If a resident has a significant weight loss or gain, a report should be given to the Director of Nursing and reviewed in Risk Meeting. Nursing should notify the physician and family of significant weight loss. |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews, review of the dialysis agreement and facility policy review, the facility failed to maintain shared communication and collaboration with the dialysis clinic regarding dialysis care and services. This affected six residents (#02, #21, #29, #44, #63, and #67) of eight residents reviewed for dialysis and had the potential to affect six additional residents (#17, #90, #33, #10, #62, #71) identified by the facility as also receiving dialysis. The facility census was 72.Findings include:<br><br>1. Review of the medical record revealed Resident #02 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure, dependence on a ventilator, dysphagia, pulmonary hypertension, end stage renal disease, dependence on renal dialysis, and gastrostomy.<br><br>Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #02 had a Brief Interview of Mental Status (BIMS) score of two out of 15, indicating severe cognitive impairment. Resident #02 was dependent on staff for oral care, and to transfers from bed to chair. The resident also required feeding tube, oxygen therapy, suctioning, tracheostomy care, invasive mechanical ventilation, and dialysis.<br><br>Review of the Treatment Administration Record (TAR) dated December 2025, revealed Resident #02 attended dialysis on 12/01/25, 12/02/25, 12/03/25, 12/04/25, 12/05/25, 12/08/25, 12/09/25, 12/10/25, 12/11/25, 12/12/25, and 12/15/25.<br><br>Review of the facility document titled Dialysis Hand Off Communication Report, dated 12/01/25, revealed the facility failed to report Resident #02's vital signs that included temperature, pulse, respiration, blood pressure, and weight prior to dialysis. The facility failed to report if labs were drawn and if Resident #02 had signs and symptoms of an infection. The facility failed to have a nurse sign the pre-dialysis hand off report.<br><br>Review of the facility document titled Dialysis Hand Off Communication Report, dated 12/02/25, revealed the facility failed to report Resident #02's vital signs that included temperature, pulse, respiration, blood pressure and weight. The facility failed to report any medical problems since last dialysis, and if labs were drawn.<br><br>Review of the facility document titled Dialysis Hand Off Communication Report, dated 12/03/25, revealed the facility failed to report Resident #02's vital signs that included temperature, pulse, respiration, blood pressure, and weights prior to dialysis. The facility also failed to report if any new medication was provided prior to last dialysis, lab draws, and if Resident #02 had signs or symptoms of infection. The facility also failed to obtain a nurse signature for the pre-dialysis portion of the communication report.<br><br>Review of the facility document titled Dialysis Hand Off Communication Report dated 12/04/25 revealed the facility failed to report Resident #02's vitals that included temperature, pulse, respiration, blood pressure, and weight prior to dialysis. The facility also failed to report any medical problems since last dialysis, any lab draws, and if Resident #02 had signs and symptoms of an infection. The facility failed to have a nurse sign the pre-dialysis hand off report.<br><br>Review of the facility document titled Dialysis Hand Off Communication Report, dated 12/05/25, revealed the facility failed to report Resident #02's temperature, pulse, respiration, blood pressure and (continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | weight vitals prior to dialysis treatment and failed to obtain a nurse signature on the Pre-Dialysis Hand Off Communication Report.<br><br>Review of the facility document titled Dialysis Hand Off Communication Report, dated 12/09/25, revealed the facility failed to notify the dialysis clinic if Resident #02 had any signs and symptoms of an infection.<br><br>Review of the facility document titled Dialysis Hand Off Communication Report, dated 12/10/25, revealed the facility failed to notify the dialysis clinic if any new medication was started since last dialysis, any medical problems since last dialysis, if labs were drawn and if Resident #02 had signs and symptoms of an infection.<br><br>Review of the facility document titled Dialysis Hand Off Communication Report, dated 12/11/25, revealed Resident #02's pre-dialysis weight was missing.<br><br>2. Review of the medical record revealed Resident #21 was admitted to the facility on [DATE] with diagnoses including end stage renal disease, anemia, disorder of phosphorus metabolism, and dependence on renal dialysis.<br><br>Review of quarterly MDS 3.0 assessment dated [DATE] revealed Resident #21 had moderate cognitive status with a BIMS score of 08 out of 15, indicating moderate cognitive impairment. Resident #21 was dependent on staff to transfer from bed to chair and required a feeding tube for nutrition. Resident #21 was on dialysis.<br><br>Review of the TAR dated December 2025, revealed Resident #21 attended dialysis 12/01/25, 12/02/25, 12/03/25, 12/04/25, 12/05/25, 12/08/25, 12/09/25, 12/10/25, 12/11/25, and 12/12/25.<br><br>Review of the undated facility document titled Dialysis Hand Off Communication Report revealed the facility failed to state Resident #21's code status, vaccine status, mental status, allergies, vitals that included temperature, pulse, respiration, blood pressure and weight prior to dialysis. The facility also failed to report Resident #21's current diet and fluid restriction, compliance with diet and fluids, any new medication since last dialysis, if labs were drawn, condition of access site prior to leaving for dialysis and if Resident #21 had signs and symptoms of infection. The facility also failed to obtain a nurse signature on the pre-dialysis communication form. The facility also failed to obtain a nurse signature on the return to facility following dialysis section regarding condition of access site, if the catheter dressing was dry and intact, if signs and symptoms of infection and failed to sign the return date and time Resident #21 returned from dialysis.<br><br>Review of the facility document titled Dialysis Hand Off Communication Report, dated 12/02/25, revealed the facility failed to notify the dialysis clinic of Resident #21's pre-dialysis weight, current diet and fluid restriction, compliance with diet and fluids, if any new medications were provided since last dialysis, any medical problems since last dialysis treatment, if labs were drawn since last dialysis treatment, the location and condition of the access site prior to leaving for dialysis and if Resident #21 had signs and symptoms of infection. The facility also failed to obtain a nurse signature and the date and time on the return to facility following dialysis and failed to indicate the condition of the access site, if the catheter dressing was dry and intact, or if resident had signs and symptoms of an infection.<br><br>Review of the facility document titled Dialysis Hand Off Communication Report, dated 12/03/25,<br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | revealed the facility failed to report Resident #21's code status, vaccination status, mental status, vital signs that included temperature, pulse, respiration, blood pressure, and weight prior to dialysis. The facility failed to notify the dialysis clinic of Resident #21's current diet and fluid restriction, compliance with diet and fluids, any new medication since last dialysis, any medical problems since last dialysis, any lab draws, the condition of the access site, and if any sign and symptoms of an infection. The facility failed to obtain a nurse signature on the pre-dialysis communication form. The facility also failed to obtain a nurse signature and the date and time Resident #21 returned from dialysis to the facility or document the condition of the access site, if the catheter dressing was dry and intact, or any sign and symptoms of infection.<br><br>Review of the facility document titled Dialysis Hand Off Communication Report dated 12/04/25 revealed the facility failed to notify the dialysis unit of Resident #21's code status, vaccination status, mental status, vitals, current diet and fluid restrictions, compliance with diet and fluids, any new medications since last dialysis, new medical problems since last dialysis, any lab draws since last dialysis, condition of access site and any signs and symptoms of an infection. The facility also failed to obtain a nurse signature on the pre-dialysis communication report. The facility also failed to have a nurse signature and the date and time of Resident #21's return to the facility following dialysis or document the condition of the access site, if the catheter dressing was dry and intact, any signs and symptoms of infection.<br><br>Review of the facility document titled Dialysis Hand Off Communication Report, dated 12/05/25, revealed the facility failed to communicate Resident #21's code status, vaccination status, mental status, vitals, current diet and fluid restriction, compliance to diet and fluids, any new medication, new medical problems or new lab draws since last dialysis treatment. The facility failed to assess the condition of the access site, and for signs and symptoms of infection. The facility did not obtain a nurse signature on the pre-dialysis communication report. The facility also failed to have a nurse sign and date the time of on Resident #21's returned to facility following dialysis and failed to assess the access site, document if the catheter dressing was dry and intact, or if resident had any sign and symptoms of an infection.<br><br>Review of the facility document titled Dialysis Hand Off Communication Report, dated 12/12/25, revealed the facility failed to notify the dialysis clinic of Resident #21's code status, mental status and weight prior to dialysis. The facility also failed to have a nurse signature with the date and time on Resident #21's return to the facility following dialysis. The facility failed to assess the access site, the catheter dressing, and signs and symptoms of infection after dialysis.<br><br>Review of the facility document titled Dialysis Hand Off Communication Report, dated 12/11/25, revealed the facility failed to inform the dialysis clinic of Resident #21's weight prior to dialysis and failed to document the time of return of facility following dialysis and the status of the access site, the catheter dressing and if Resident #21 had signs and symptoms of infection.<br><br>Review of the facility document titled Dialysis Hand Off Communication Report, dated 12/10/25, revealed the facility failed to have a nurse signature and date and time of Resident #21's return to the facility from dialysis and the condition of the access site, catheter dressing, and if Resident #21 had signs and symptoms of an infection.<br><br>3. Review of the medical record revealed Resident #63 was admitted to the facility on [DATE] with diagnoses including chronic kidney disease stage five, hyperkalemia, diabetes mellitus, hypertension and anemia.<br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the admission MDS 3.0 assessment dated [DATE] revealed Resident #63 had intact cognition, needed substantial assistance to transfer from bed to chair, was on a therapeutic diet, and was receiving dialysis.<br><br>Review of the TAR dated December 2025, revealed Resident #63 attended dialysis on 12/01/25, 12/02/25, 12/03/25, 12/04/25, 12/05/25, 12/08/25, 12/09/25, 12/10/25, 12/11/25, and 12/12/25.<br><br>Review of the facility document titled Dialysis Hand Off Communication Report, dated 12/01/25, revealed the facility failed to have a nurse signature for the pre-dialysis communication form and inform the dialysis clinic of Resident #63's code status, vaccine status, mental status, vital signs, current diet and fluid restriction, compliance to diet and fluids, any new medication, new medical problems, or new lab draws prior to last dialysis treatment. The facility failed to document the condition of the access site and if Resident #63 had signs and symptoms of infection. The facility also failed to have a nurse signature and the date and time Resident #63 returned to the facility following dialysis, the condition of the access site, the condition of the catheter dressing, and if Resident #63 had any signs or symptoms of infection.<br><br>Review of the facility document titled Dialysis Hand Off Communication Report, dated 12/02/25, revealed the facility failed to communicate prior to dialysis Resident #63's weight, current diet and fluid restriction, compliance with diet and fluids, any new medication, new medical problems, or new lab draws since last dialysis treatment. The facility failed to communicate if Resident #63 had any signs or symptoms of infection prior to dialysis. The facility failed to have a nurse signature with date and time of Resident #63's return to facility following dialysis and the condition of the dialysis site, catheter dressing, and if Resident #63 had signs and symptoms of infection.<br><br>Review of the facility document titled Dialysis Hand Off Communication Report, dated by the dialysis clinic as 12/03/25, revealed the facility failed to obtain a nurse signature prior to dialysis and communicate Resident #63's code status, vaccine status, mental status, vital signs, current diet and fluid restrictions, compliance with diet and fluids, any new medication, new medical problems, new lab draws since last dialysis treatment. The facility failed to communicate the condition of the access site, and if Resident #63 had signs and symptoms of an infection. The facility failed to obtain a nurse signature, date and time of Resident #63's return to the facility from dialysis and the condition of the access site, condition of the catheter dressing, and if Resident #63 had signs and symptoms of an infection.<br><br>Review of the facility document titled Dialysis Hand Off Communication Report, dated 12/04/25, revealed the facility failed to obtain a nurse signature prior to leaving for dialysis and communicate to the dialysis clinic Resident #63's code status, vaccine status, mental status, vital signs, current diet and fluid restriction, compliance to diet and fluid restriction, any new medication, labs or medical condition since last dialysis treatment. The facility failed to communicate the condition of the access site, and if Resident #63 had signs and symptoms of an infection. The facility failed to obtain a nurse signature, date and time Resident 63 returned to the facility from dialysis and failed to assess the access site, catheter dressing, and if Resident #63 had signs and symptoms of an infection.<br><br>Review of the facility document titled Dialysis Hand Off Communication Report, dated 12/05/25, revealed the facility failed to obtain a nurse signature prior to Resident #63 leaving for dialysis and failed to communicate to the dialysis unit Resident #63's code status, vaccine status, mental status, allergies, vital signs, current diet and fluid restriction, compliance with diet and fluid restriction, any new medication, new labs or medical condition since last dialysis treatment. The facility failed to<br>(continued on next page) |

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|---|---|---|---|
| | 365539 | A. Building<br>B. Wing | 12/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Warren Nursing & Rehab | 2473 North Rd NE<br>Warren, OH 44483 |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | communicate the condition of the access site and if Resident #63 had signs and symptoms of an infection. The facility failed to obtain a nurse signature and date and time Resident #63 returned to the unit from dialysis and the status of the access site, the catheter dressing, and if Resident #63 had signs and symptoms of an infection.<br><br>Review of the facility document titled Dialysis Hand Off Communication Report, dated 12/12/25, revealed the facility failed to communicate Resident 63's weight prior to dialysis, current diet and fluid restriction, compliance to diet and fluid restriction, any new medication, new labs or new medical condition since last dialysis treatment. The facility failed to obtain a nurse signature of the date and time Resident #63 returned to the from dialysis and the condition of the access site, the condition of the catheter dressing, and if Resident #63 had signs and symptoms of an infection.<br><br>Interview on 12/11/25 at 4:36 P.M. with Licensed Practical Nurse (LPN) #844 revealed the night nurse was to fill out the Dialysis Communication Report if a resident left early in the morning for dialysis. LPN #844 also stated when a resident returned to the unit the nurse on duty was to receive the hand off communication report and was to sign the report. The dialysis hand off reports were to be reviewed by the Director of Nursing (DON).<br><br>Review of the facility document titled Long Term Care Facility Renal Dialysis Coordination Agreement, dated 10/19/20, section Six: Communication, revealed emergency and non-emergency changes in dialysis residents would be communicated in writing. The long-term facility would notify the dialysis facility in writing when a resident refused or demonstrated noncompliance with medical management related to renal replacement therapy such as diet, fluid restriction and medications.<br><br>4. A review of the medical record for Resident #29 revealed a date of admission of 12/09/25. Significant diagnoses included end stage renal disease, other complications of kidney transplant, and dependence on renal dialysis. Significant orders included dialysis in-house with Dialyze Direct, Monday through Friday. There were no orders for pre and post dialysis assessments to be completed.<br><br>Review of the annual MDS 3.0 assessment dated [DATE] revealed a BIMS score of 15, indicating the resident was cognitively intact. The MDS also revealed Resident #29 received dialysis.<br><br>Review of the care plan dated 10/22/25 revealed Resident #29 had end stage renal disease requiring hemodialysis with history of kidney transplant. Interventions included coordinating with dialysis regarding labs, diet, weight, and medication as necessary. Dialysis in house with Dialyze Direct Monday through Friday with chair time varying. Interventions also included monitoring for change in mental status, monitoring for signs and symptoms of infection, and monitoring for signs and symptoms of hypovolemia or hypervolemia (dangerously low or high volume of blood or extracellular fluids in the body).<br><br>A review of a facility documents titled; Dialysis Handoff Communication Reports for Resident #29 dated 12/02/25, 12/04/25, 12/05/25 and 12/11/25 revealed the facility failed to report Resident #29's vital signs that included temperature, pulse, respiration, blood pressure, and weight pre and post dialysis. The facility failed to report if labs were drawn and if Resident #29 had signs and symptoms of an infection. The facility failed to have a nurse sign the pre-dialysis and post-dialysis hand off reports.<br><br>5. A review of the medical record for Resident #44 revealed a date of admission of 11/11/25. Significant diagnoses included acute kidney failure. Significant orders included dialysis in-house with (continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Dialyze Direct, Monday through Friday. There were no orders for pre and post dialysis assessments to be completed.<br><br>Review of the care plan dated 11/11/25 revealed Resident #44 had the care need of dialysis Monday through Friday in-house. There was nothing in the care plan regarding pre and post dialysis assessments. There was nothing within the care plan indicating communication with dialysis regarding monitoring for a change in mental status, monitoring for signs and symptoms of infection, and monitoring for signs and symptoms of hypovolemia or hypervolemia.<br><br>Review of the Medicare five-day MDS 3.0 assessment dated [DATE] revealed a BIMS score of 15, indicating the resident was cognitively intact. The MDS also revealed Resident #44 received dialysis.<br><br>A review of a facility documents titled Dialysis Handoff Communication Reports for Resident #44 revealed the following:<br><br>- 12/01/25: No vital signs that included temperature, pulse, respiration, blood pressure, and weight prior to dialysis. There was no post dialysis assessment completed by the facility.<br><br>- 12/02/25: No pre or post dialysis assessments completed. The sections of the form were blank.<br><br>- 12/03/25: No vital signs that included temperature, pulse, respiration, blood pressure, and weight prior to dialysis. There was no post dialysis assessment completed by the facility.<br><br>- 12/04/25: No pre or post dialysis assessments completed. The sections of the form were blank.<br><br>- 12/05/25: No vital signs that included temperature, pulse, respiration, blood pressure, and weight prior to dialysis. There was no post dialysis assessment completed by the facility.<br><br>- 12/08/25: There was no post dialysis assessment completed by the facility.<br><br>- 12/10/25: No vital signs that included temperature, pulse, respiration, blood pressure, and weight prior to dialysis. There was no post dialysis assessment completed by the facility.<br><br>- 12/11/25: No vital signs that included temperature, pulse, respiration, blood pressure, and weight prior to dialysis. There was no post dialysis assessment completed by the facility.<br><br>6. A review of the medical record for Resident #67 revealed a date of admission of 05/28/25. Significant diagnoses included end stage renal disease. Significant orders included dialysis in-house with Dialyze Direct, Monday through Friday. There were no orders for pre and post dialysis assessments to be completed.<br><br>Review of the quarterly MDS 3.0 assessment dated [DATE] revealed a BIMS score of 00, indicating the resident had severe cognitive deficit or the resident was not understood. The MDS also indicated Resident #67 received dialysis.<br><br>Review of the care plan dated 12/29/25 revealed Resident #67 had a care need of dialysis. Interventions included dialysis Monday through Friday. There was nothing within the care plan indicating communication with dialysis regarding monitoring for a change in mental status, monitoring for signs and symptoms of infection, and monitoring for signs and symptoms of hypovolemia or (continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | hypervolemia.<br><br>A review of a facility documents titled Dialysis Handoff Communication Reports for Resident # 67 revealed the following:<br><br>- 12/01/25: No pre or post dialysis assessments completed. The sections of the form were blank.<br><br>- 12/02/25: No post dialysis assessment. The section of the form was blank.<br><br>- 12/03/25: No pre or post dialysis assessments completed. The sections of the form were blank.<br><br>- 12/04/25: No pre or post dialysis assessments completed. The sections of the form were blank.<br><br>- 12/05/25: No pre or post dialysis assessments completed. The sections of the form were blank.<br><br>On 12/10/25 at 4:00 P.M. an interview with Dialysis Registered Nurse (DRN) #841 revealed the facility was to complete pre and post dialysis assessments on the communication document. DRN #844 further stated most often the pre and post dialysis assessments are blank for those residents' receiving dialysis.<br><br>On 12/15/25 at 2:40 P.M. an interview with DON verified the lack of pre and post dialysis pre and assessments for Residents #02, #21, #29, #44, #63 and #67. The DON also verified no physician orders for pre and post dialysis assessments or care plan interventions for Residents #02, #21, #29, #44, #63 and #67.<br><br>A review of the policy titled End Stage Renal Disease, Care of a Resident with, dated 09/24, revealed residents with end-stage renal disease will be cared for according to currently recognized standards of care. The policy further stated staff caring for residents with end-stage renal disease, including residents receiving dialysis care shall assess data that is to be gathered about the residents' condition on a daily or per shift basis, review signs and symptoms of worsening condition or complications of end stage renal disease, and monitor care of grafts and fistulas.<br><br>This deficient practice represents noncompliance investigated under Complaint Number 2687759. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to remove expired wound and tracheostomy care supplies and enteral feeding formula from storage to prevent usage and failed to securely store medications for Residents #30 and #51. This affected two residents (#30 and #51) and had the potential to affect all 72 residents residing in the facility.Findings include:1. Observation on [DATE] at 11:04 A.M. of Resident #51 revealed the resident was lying in bed. On the overbed table was a clear medication administration cup with four tablets of varying size and one capsule. Interview at the time of the observation with Resident #51 revealed she was not sure how long the pills had been there. Interview at the time of the observation with Licensed Practical Nurse (LPN) #380 verified the pills and capsule inside the medication cup were left on the resident's bedside table. The nurse stated he did not leave the pills at the bedside and believed they were from the previous shift.Review of the medical record for Resident #51 revealed an admission date of [DATE]. Significant diagnoses included chronic respiratory failure, chronic obstructive pulmonary disease, congestive heart failure, morbid obesity, dependence on a respirator, major depressive disorder, anxiety disorder, tracheostomy status, and post-traumatic stress disorder. Physician orders effective [DATE] included bupropion 150 milligrams (mg) by mouth in the morning for depression, buspirone 10 mg, one tablet by mouth twice daily for anxiety, venlafaxine 150 mg, one capsule by mouth twice daily for depression, trazodone 50 mg, one tablet by mouth at bedtime for insomnia, and xanax 1 mg, one tablet three times daily for anxiety. There was no evidence in the medical record to indicate Resident #51 self-administered medications. Review of the admission Minimal Data Set (MDS) assessment dated [DATE] revealed Resident #51 had no cognitive impairment.2. Observation on [DATE] at 8:45 A.M. of Resident #30 revealed the resident was lying in bed. On the bedside table was a plastic medication administration cup with one small white tablet. Interview at the time of the observation with Resident #30 revealed she thought it was her blood pressure pill and could not recall how long the medication had been there. Interview at the time of the observation with Registered Nurse (RN) #418 verified the small white tablet was left at the resident's bedside.Review of the medical record for Resident #30 revealed an admission date of [DATE]. Significant diagnoses included urinary tract infection, need for assistance with personal care, weakness, morbid obesity, bipolar disorder, and anxiety disorder. Physician orders effective [DATE] included labetalol 100 mg, one tablet by mouth every eight hours for hypertension. There was no evidence in the medical record to indicate Resident #30 self-administered medications.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #30 had no cognitive impairment.3. Observation on [DATE] at 2:27 P.M. of the medication storage room located on the Dogwood Unit revealed two tracheostomy care kits with expiration dates of [DATE], six tracheostomy care kits with expiration dates of [DATE], and three collagen dressings (wound dressings to promote healing) with expiration dates of [DATE]. Interview at the time of the observation with Registered Nurse (RN) #431 and the Director of Nursing (DON) verified the expired items were stored for usage.Observation on [DATE] at 2:50 P.M. of the medication storage room located on the Aspen Unit revealed five eight-ounce cartons of enteral feeding formula with expiration dates of [DATE], one case of enteral feeding formula with expiration dates of [DATE], and one case of four-gram fiber packets (a dietary supplement) with expiration dates of [DATE]. Interview at the time of the observation with RN #431 and the DON verified the expired items were stored for usage.Review of the facility policy entitled, Storage of Medication, dated [DATE] revealed the facility stored all drugs and biologicals in a safe, secure and orderly manner. All discontinued, outdated or deteriorated drugs or biologicals were returned to the dispensing pharmacy or destroyed. Review of the facility policy entitled, Administering Medication, (continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | dated [DATE] revealed medications were administered in a safe and timely manner as prescribed. Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary team had determined that they have the decision-making capacity to do so. This deficiency represents non-compliance investigated under Complaint Number 2668507. |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>Based on observation, interview, record review, and review of facility policy, the facility failed to ensure sugar-free condiments were available in accordance with the planned consistent carbohydrate, limited concentrated sweets menu. This had the potential to affect 10 residents (Resident #17, #29, #32, #34, #36, #03, #05, #65, #68, #71) the facility identified as having a physician order for consistent carbohydrate, low concentrated sweets diet of 57 residents who received meals from the facility kitchen. The facility identified 15 residents (Resident #90, #18, #21, #22, #25, #27, #02, #10, #41, #42, #11, #58, #01, #62, #67) who did not eat by mouth (NPO). The facility census was 72.Findings include: An interview on 12/17/25 at 1:30 P.M. with Licensed Practical Nurse (LPN) #316 revealed LPN #316 had a concern about resident blood sugars with the residents with diabetes. LPN #316 stated diabetic residents used to receive sugar-free condiments but recently did not receive sugar-free syrup or sugar-free jelly any more on the meal trays and instead were being served regular jelly and regular syrup which had alot of sugar in it for diabetics. An observation on 12/17/25 at 3:00 P.M. of the dry kitchen storage area and general kitchen environment revealed there was no sugar-free syrup or sugar-free jelly available for resident use.An interview on 12/17/25 at 3:10 P.M. with Diet Manager (DM) #317 verified residents were to receive sugar-free syrup and sugar-free jelly according to the Consistent Carbohydrate Diet Spreadsheet for the facility. DM #317 verified there was none in the kitchen because none had been ordered. An interview on 12/22/25 at 8:25 A.M. with Dietitian #820 revealed she was to inspect the kitchen monthly but was not sure if the facility had appropriate consistent carbohydrate food items according the to facility spreadsheets. She stated if a resident was on a consistent carbohydrate diet the facility should have available sugar-free condiments for residents because sugar-free condiments were in alignment with the consistent carbohydrate diet.Review of facility Diet Spreadsheet Day 26, Thursday, revealed a CCHO ( Consistent Carbohydrate diet) LCS ( Limited Concentrated Sweets) diet indicated at breakfast diet syrup was to be served with the waffle as well as bacon, unsweetened cereal, juice, milk and margarine. Review of facility Diet Spreadsheet Day 17, Tuesday, CCHO (LCS) diet indicated diet syrup was to be served with a blueberry pancake, sausage link, unsweetened cereal and margarine. Review of facility Diet Spreadsheet Day 31, Tuesday, the CCHO (LCS) diet indicated diet jelly was to be served with a bagel, cream cheese, sausage links, mixed fruit cup and unsweetened cereal and milk. Review of the facility Diet Spreadsheet Day 25, Wednesday, revealed the CCHO (LCS) diet indicated diet jelly was to be served with a breakfast bowl, toast, margarine, unsweetened cereal, juice and milk.Review of facility policy titled CCHO Diet (LCS) (Consistent Carbohydrate) Limited Concentrated Sweets dated year 2022, revealed the CCHO diet followed a regular diet with smaller portions of regular desserts, and utilized sugar substitutes, diet jelly and diet syrup. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation and interview, the facility did not serve food in a manner consistent with professional standards for food service safety. This had the potential to affect 35 residents (#3, #8, #9,#12, #13, #14, #16, #19, #23, #26, #28, #29, #30, #31, #32, #33, #34, #35, #37, #38, #44, #47, #48, #49, #51, #50, #55, #56, #57, #63, #64, #65, #66, #83, and #84) receiving meals from the second floor kitchenette out of 57 residents who received meals from the facility. The facility identified 15 residents (Resident #90, #18, #21, #22, #25, #27, #02, #10, #41, #42, #11, #58, #01, #62, #67) who did not eat by mouth (NPO). The facility census was 72.Findings include:An observation was conducted on 12/18/25 at 5:00 P.M. of the evening meal service on the second floor and revealed an open to air food transport cart was being pushed off the elevator towards the kitchenette near the common areas dining room. On the cart were three full trays of mini pizza that were not covered during transport. An interview on 12/18/25 at 5:05 P.M. with Dietary Manager (DM) #317 verified the uncovered trays of pizza were transported uncovered from the kitchen on the first floor, up the elevator and to the second floor dining room for the resident meal service. DM #317 verified the pizza should have been covered during transport. This deficiency represents non-compliance investigated under Complaint Number 2687759. |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>Based on record review, interview and review of facility policy, the facility failed to ensure resident consents or declinations were obtained for influenza and pneumococcal vaccines, and the facility failed to document site of administration, lot number, and expiration dates for administered vaccines. This affected five residents (Resident #5, #20, #25, #29, and #38) of seven residents reviewed for vaccinations. The facility census was 72.Findings include:1. Review of Resident #5's medical record revealed an admission date of 03/30/20. Diagnoses included Major Depressive Disorder (MDD), bipolar disorder, hypertension, congestive heart failure and chronic kidney disease stage III.Review of Resident #5's influenza and pneumococcal vaccination consent form dated 09/17/25 revealed the resident consented to both vaccinations.Review of Resident #5's Medication Administration Record (MAR) dated September 2025 revealed the resident received her influenza vaccination on 09/23/25 and she received her pneumococcal vaccination on 09/24/25; however, there was no required documentation such as lot number, expiration date, and site of administration.2. Review of Resident #20's medical record revealed an admission date of 08/27/25. Diagnoses included acute on chronic respiratory failure, end stage renal disease, acute on chronic congestive heart failure, history or sepsis, and COVID-19.Further review of Resident #20's medical record including physician orders, MARs, and progress notes revealed there was no consent or declination present for the influenza or pneumococcal vaccines.3. Review of Resident #25's medical record revealed an admission date of 04/18/25. Diagnoses included chronic respiratory failure with hypoxia, hypertension, tracheostomy status, gastrostomy status, and traumatic subdural hemorrhage.Review of Resident #25's pneumococcal vaccination consent form dated 04/28/25 revealed the resident consented for the vaccine. Infection Preventionist (IP) Registered Nurse (RN) #431 was unable to provide surveyor with influenza vaccination consent or declination form.Further review of Resident #25's medical record including physician orders, MARs and progress notes revealed there was documentation present Resident #25 received their pneumococcal vaccination in April 2025, but there was no documentation of the administration site, lot number or expiration date. Additionally, there was no documentation present related to consent or declination of influenza vaccination.4. Review of Resident #29's medical record revealed an admission date of 12/09/25. Diagnoses included dependence on renal dialysis, end stage renal disease, chronic obstructive pulmonary disease, and pulmonary hypertension.Further review of Resident #29's medical record revealed the resident received the pneumococcal vaccination on 05/07/25. There was no consent or declination present for the influenza vaccination.5. Review of Resident #38's medical record revealed an admission date of 10/06/25. Diagnoses included type II diabetes, major depressive disorder, hypertension, tracheostomy status, ventilator dependency, acute pulmonary edema and acute on chronic respiratory failure with hypoxia.Further review of Resident #38's medical record including physician orders, MARs, and progress notes revealed there was no consent or declination present for the influenza or pneumococcal vaccines.An interview on 12/31/25 at 12:36 P.M. with IP RN #431 confirmed when staff give the influenza or pneumococcal vaccination they are to document administration site, lot number and expiration date. IP RN #431 stated vaccinations are not to be given without signed consent. IP RN #431 confirmed Resident #5 was given her influenza vaccination on 09/23/25 and she received her pneumococcal vaccination on 09/24/25; however, there was no required documentation such as lot number, expiration date, and site of administration. IP RN #431 confirmed there was no consent or declination present for the influenza or pneumococcal vaccines for Resident #20. IP RN #431 was unable to provide surveyor with influenza vaccination consent or declination form for Resident #25 nor was there documentation of administration site, lot number, or expiration date for Resident #25's pneumococcal vaccination. IP RN #431 confirmed for Resident #29 there was no consent or declination present for the influenza vaccination. Finally, IP RN #431 confirmed there was no consent or declination available for Resident #38.Review of the facility policy titled Influenza Vaccine, last revised October 2019 revealed all<br>(continued on next page) |

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|---|---|---|---|
| | 365539 | A. Building<br>B. Wing | 12/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Warren Nursing & Rehab | 2473 North Rd NE<br>Warren, OH 44483 |

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|---|---|
| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | residents will be offered the influenza vaccine annually and staff were to ensure there was a signed consent or declination for the vaccine and if administered staff were to document the date of vaccination, lot number, expiration date, person administering the vaccine and the site of administration in the resident medical record.Review of facility policy titled Pneumococcal Vaccine, last revised October 2019, revealed all residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Staff were to ensure there was a signed consent or declination for the vaccine and if administered staff were to document the date of vaccination, lot number, expiration date, person administering the vaccine and the site of administration in the resident medical record. |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.<br><br>Based on record review, interview and review of facility policy, the facility failed to ensure resident consent or declinations were obtained for COVID-19 vaccinations. This affected five residents (Resident #5, #20, #25, #29, and #38) of seven residents reviewed for vaccinations. The facility census was 72.Findings include: 1. Review of Resident #5's medical record revealed an admission date of 03/30/20. Diagnoses included Major Depressive Disorder (MDD), bipolar disorder, hypertension, congestive heart failure and chronic kidney disease stage III.Review of Resident #5's COVID-19 vaccination consent form dated 09/17/25 revealed the resident consented to the vaccination.Review of Resident #5's Medication Administration Record (MAR) dated September 2025 revealed the resident was not administered the COVID-19 vaccination.2. Review of Resident #20's medical record revealed an admission date of 08/27/25. Diagnoses included acute on chronic respiratory failure, end stage renal disease, acute on chronic congestive heart failure, history or sepsis, and COVID-19.Further review of Resident #20's medical record including physician orders, MARs, and progress notes revealed there was no consent or declination present for COVID-19 vaccination.3. Review of Resident #25's medical record revealed and admission date of 04/18/25. Diagnoses included chronic respiratory failure with hypoxia, hypertension, tracheostomy status, gastrostomy status, and traumatic subdural hemorrhage.Further review of Resident #25's medical record including physician orders, MARs and progress notes revealed there was no consent or declination present for COVID-19 vaccination.4. Review of Resident #29's medical record revealed an admission date of 12/09/25. Diagnosis included dependence on renal dialysis, end stage renal disease, chronic obstructive pulmonary disease, and pulmonary hypertension.Further review of Resident #29's medical record revealed there was no consent or declination present for the COVID-19 vaccination present.5. Review of Resident #38's medical record revealed an admission date of 10/06/25. Diagnosis included type II diabetes, major depressive disorder, hypertension, tracheostomy status, ventilator dependency, acute pulmonary edema and acute on chronic respiratory failure with hypoxia.Further review of Resident #38's medical record including physician orders, MARs, and progress notes revealed there was no consent or declination present for the COVID-19 vaccination.Interview on 12/31/25 at 12:36 P.M. with Infection Prevention (IP) Registered Nurse (RN) #431 revealed Resident #5 consented to receive the COVID-19 vaccination but it was not administered. IP RN #341 confirmed there were no consent or declinations available for Resident #20, #25, #29, and #38. IP RN #431 stated she was not sure why Resident #5 did not receive the vaccination after consenting to it.Review of facility policy titled Coronavirus Disease (COVID-19)-Vaccination of Residents, last revised November 2021 revealed staff were to offer all residents the COVID-19 vaccination and staff were to document consent or declination of the vaccine and if administered staff were to document the date of vaccination, lot number, expiration date, person administering the vaccine and the site of administration in the resident medical record. |

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|---|---|
| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and review of facility policy, the facility failed to have call lights within reach for Resident #41, #50 and #56. This affected three residents ( #41, #50 and #56) of 72 residents observed for call lights. The facility census was 72. Findings include: 1. Review of the medical record for Resident #41 revealed an admission date of 09/22/23 with diagnoses including chronic respiratory failure and nontraumatic intercerebral hemorrhage. There were no physician orders regarding call lights.Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed Resident #41 had severe cognitive impairment and impairment bilaterally to the upper and lower extremities. Resident #41 was dependent for all activities of daily living (ADL).Review of the care plan dated 12/17/25 revealed Resident #41 had a potential for falls related to limited mobility and post cerebral vascular accident. Interventions included ensure call light was available to resident's unaffected side. The care plan also revealed Resident #41 to have a communication problem related to being nonverbal and does not respond to verbal or tactile stimulation. Interventions included for the call light to be in reach.On 12/04/25 at 11:23 A.M. Resident #41 was observed to be lying in their bed. The call light was noted to be wrapped around the over bed light that was approximately five feet over the head of Resident #41and completely out of her reach. Licensed Practical Nurse (LPN) #380 was present during the observation and verified the findings. 2. Review of medical records for Resident #50 revealed an admission date of 02/05/21 with diagnoses including heart failure, chronic obstructive pulmonary disease (COPD) and diabetes mellitus type two. There were no physician orders regarding call light use.Review of the quarterly MDS assessment dated [DATE] revealed Resident #50 was cognitively intact.Review of the care plan dated 08/06/25 revealed Resident #50 was at risk for falls related to COPD. Interventions included be sure the resident's call light and personal items were within reach and encourage the resident to use the light for assistance as needed. On 12/04/25 at 10:37 A.M. an observation of Resident #50 revealed them to be lying in bed. The call light was noted to be wrapped around the overbed light that was located across the room. LPN #380 verified the location of the call light being out of reach for Resident #50 at the time of the observation. 3. Review of the medical record for Resident #56 revealed a date of admission as 05/12/17 with diagnoses including unqualified visual loss of both eyes and expressive language disorder. There were no physician orders regarding call light use.Review of the annual MDS assessment dated [DATE] revealed Resident #56 was cognitively intact.Review of the care plan dated 10/22/25 revealed Resident #56 had the potential for falls related to blindness. Interventions included encourage resident to use the call light for assistance and maintain the call light within reach.On 12/03/25 at 1:51 P.M. an observation of Resident #56 revealed them to be lying in bed. The call light was wrapped around the overbed light approximately five feet over the head of the resident. Certified Nurse Aide #311 verified the call light placement at the time of the observation.A review of the facility policy titled Answering Call Lights, undated, revealed when leaving the room be sure the call light is placed within the resident reach. |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews and facility policy review the facility failed to ensure resident advanced directives (code status) were accurate. This affected one resident (#6) of 53 residents reviewed for the annual survey. The facility census was 72.Findings include: Review of Resident #6's medical record revealed the resident was admitted on [DATE] with diagnosis that included: major depressive disorder, dementia, intracranial injury, essential hypertension, anxiety disorder, occlusion and stenosis of unspecified cerebral artery, alcohol dependence and unspecified psychosis. Record review revealed Resident #6 had an advanced directive order dated 05/07/20 for Full Code status (all life sustaining measures in the event of a cardiac or respiratory arrest).Review of a care plan dated 03/19/25 revealed the resident was a full code. Review of Resident #6's Minimum Data Set (MDS) dated [DATE] revealed the resident had moderate cognitive impairment. Review of Resident #6 Care Conference Note dated 11/18/25 revealed the resident's mother requested resident's code status be changed from a Full Code to a Do Not Resuscitate Comfort Care (DNRCC) (no life saving measures in the event of cardiac or respiratory arrest). Interview on 12/4/25 at 1:23 P.M. with Resident #6's mother confirmed she wanted the resident's code status changed to a DNRCC.Interview on 12/11/25 at 2:38 P.M. with Director of Social Services (DSS) #351 revealed Resident #6's last care conference was completed on 11/18/25 with DSS #351 and the nurse unit manager. DSS #351 revealed she was unable to change code status and the nurse unit manager was supposed to get the order updated and signed by the resident's nurse practitioner. DSS #351 stated she would follow-up to ensure the order was updated.Interview on 12/15/2025 at 1:16 P.M. with Licensed Practical Nurse (LPN) #316 verified Resident #6's advanced directive status was changed to DNRCC and the DNRCC form was on the nurse's desk this morning (12/15/25) and was signed by the physician. LPN #316 stated the updated form was provided to the secretary to scan into Resident #6's medical record.Review of facility Advance Director Policy with a revised date of December 2016 revealed:13. The Interdisciplinary Team will review annually with the resident his or her advanced directives to ensure that such directives are still the wishes of the resident.14. The Director of Nursing Services or designee will notify the Attending Physician of advanced directives so that appropriate orders can be documented in the resident's medical record and plan of care. |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and policy review the facility failed to ensure they notified the emergency contact of a resident's change in condition. This affected one resident (Resident #38) of one resident reviewed for notification of change. The facility census was 72.Findings include: Review of Resident #38's medical record revealed an admission date of 10/06/25 and a discharge date to the hospital on [DATE]. Diagnosis included acute on chronic respiratory failure, ventilator dependent, neurogenic bladder, urinary tract infection, hypertension, and tracheostomy status.Review of Resident #38's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition, required substantial to maximal assistance with eating, and was dependent on staff for all other Activities of Daily Living (ADLs) including oral hygiene, toileting hygiene, showers, incontinence care, dressing, and bed mobility.Review of progress notes dated 12/19/25 at 2:58 P.M. revealed Resident #38 was experiencing a change in condition including bleeding with suctioning, blood in urine and vital signs documented as temperature 102.1 degrees Fahrenheit (F), respiratory rate 31 breaths per minute, pulse oximetry 66 percent. Resident was removed from the ventilator and manually bagged on 15 liters of oxygen by the respiratory therapist who suctioned for moderate amounts of brown bloody secretions. The resident was noted to have dried blood on front of teeth but refused oral care by the Respiratory Therapist and Certified Nursing Assistant (CNA). Physician was notified and order given to send to the Emergency room. Resident was admitted to the hospital.Review of Change in Condition assessment dated [DATE] and authored by the Director of Nursing (DON) revealed Resident #38's family was not notified of the hospital transfer.Review of Progress note dated 12/25/25 at 11:00 A.M. revealed the resident's husband showed up to the facility to visit and found the resident was not there and was unaware of this. DON notified at this this time of husband's concerns.Interview on 12/29/25 at 4:45 P.M. with Resident #38's husband revealed he arrived to the facility on [DATE] to visit his wife and was extremely upset when he found out his wife was not in her room. He stated he went to the nurse and found she had been sent to the hospital on [DATE] and admitted to the hospital. He stated he was extremely upset he was not notified the resident was sent to the ER and admitted to the hospital on [DATE] to the Intensive Care Unit (ICU) and was not doing well.Interview on 12/30/25 at 4:15 P.M. with the DON revealed she confirmed she was contacted on 12/25/25 by the nurse on duty and notified of Resident #38's husband was at the facility and was upset no one called and notified him of Resident 38's change in condition and stated he should have been called as he was listed as emergency contact number one and the resident was not able to make decisions on her care at the time of transfer due to altered mental status and emergent situation.Review of facility policy titled Change in a Resident's Condition or Status, last revised May 2024, revealed the facility shall promptly notify the resident, his or her Attending Physician, and representative of changes in the resident's medical/mental condition and or status. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to develop and implement comprehensive care plans for residents. This affected three residents (#13, #14, and #19) of three residents reviewed for comprehensive care plan implementation. The facility census was 72.Findings include:1. Review of Resident #19's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses of type 2 diabetes mellitus with hyperglycemia, adult failure to thrive, homelessness, mood disorder, glaucoma, Guillain-Barre syndrome, obstructive sleep apnea, and panic disorder.<br><br>Review of Resident #19's Minimum Data Set (MDS) 3.0 dated 10/26/25 revealed a BIMS score 15, indicating intact cognition. The MDS also revealed Resident #19 required set-up/supervision with all Activities of Daily Living and Mobility. The MDS also indicated the resident showed little interest or pleasure in doing things almost daily.<br><br>Further review of Resident #19's Medical Record revealed on 11/11/25, the Resident signed a consent to receive mental health day program treatment which consisted of daily group therapy, as well as additional individual therapeutic behavioral support, psychiatric medication management, individual psychotherapy and family psychotherapy.<br><br>Review of Resident #19's undated care plan revealed the resident was at risk for social isolation due to anxiety, depression, and stated little pleasure or interest in doing things. Goals included the resident would maintain social relationships with staff and peers as evidenced by initiating social encounters daily through next review and interventions included allowing the resident to express feelings and desires, a calendar in the resident's room, inviting the resident to structured activities while respecting her right to refuse, praising involvement in activities, providing encouragement, providing supplies and assistance as needed for self-directed pursuits and reporting signs of isolation. Resident #19's care plan included no focus areas, goals, or interventions related to a mental health program.<br><br>Review of Resident #19's current physician orders revealed orders for Buspirone HCl Oral Tablet 15 MG (Buspirone HCl) Give 15 mg by mouth two times a day for anxiety, Duloxetine HCl Oral Capsule Delayed Release Sprinkle 60 MG (Duloxetine HCl) Give 60 mg by mouth in the morning for Depression and Divalproex Sodium Oral Tablet Delayed Release 125 MG (Divalproex Sodium) Give 125 mg by mouth every 8 hours for mood.<br><br>An interview with MDS Nurse #418 on 12/17/25 at 1:52 P.M. confirmed Resident #19's care plan did not contain any focus areas, goals, or interventions related to a mental health day program.<br><br>2. Review of Resident #13's medical record revealed the resident was admitted on [DATE] with diagnoses of acute kidney failure, dehydration, anemia, osteoarthritis, chronic pain, hypertension, hyperlipidemia, major depressive disorder, moderate protein-calorie malnutrition, personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits, muscle weakness, and need for assistance with personal care.<br><br>Review of Resident #13's MDS assessment dated [DATE] revealed a BIMS score of 14, indicating intact cognition. Review of the MDS also revealed Resident #13 required set-up with oral care and (continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | eating, maximum assistance with dressing and bathing and was dependent on staff for toileting, was verbally inappropriate toward staff at times and reported feeling down or depressed less than daily.<br><br>Interview with Resident #13 on 12/11/25 at 12:37 P.M. indicated he was alert and oriented, pleasant, and talkative and stated he hoped to go home soon to help take care of his ex-wife. During the interview, the resident also indicated no staff member had discussed discharge planning with him.<br><br>Interview with the Social Services Designee (SSD) #351 on 12/15/25 4:46 P.M. revealed she was aware of resident's hope to discharge home with his ex-wife after rehab but stated discharge to the community was not appropriate at the time, as the resident was unable to care for himself. SSD #351 further stated she did not have a part in creating the comprehensive care plan and was not responsible to care plan psychosocial needs or interventions for residents.<br><br>Interview with MDS Nurse #418 on 12/17/25 at 1:52 P.M. revealed she was responsible for creating the entire care plan except for dietary and activities needs. She stated she takes into consideration admission paperwork, hospital paperwork, doctor's orders, and stated she would expect to see self-care needs, skin integrity, resident care needs, isolation precautions, dialysis, pain and discharge planning needs addressed in the comprehensive care plan. MDS Nurse #418 verified that discharge plans were not included in Resident #13's comprehensive care plan.<br><br>Review of the Social Service Designee's job description dated and acknowledged on 07/14/25 revealed it was the responsibility of the Social Service Designee to participate in discharge planning, develop and implement social care plans and resident assessments and to assist in developing a written plan of care (preliminary and comprehensive) for each resident that identifies the problems/needs of the resident and the goals to be accomplished for each problem/need identified relating to mood, behavior, psychosocial wellbeing, discharge status, code status and smoking, if applicable and to review and revise care plans and assessments as necessary, at a minimum quarterly.<br><br>3. A review of medical records for Resident #14 revealed the date of admission as 02/06/25. Significant diagnoses included post-traumatic stress disorder (PTSD). Significant orders included haloperidol ( an antipsychotic medication) 10 milligrams at bedtime for PTSD.<br><br>A quarterly MDS assessment dated [DATE] revealed a BIMS of 15 (cognitively intact). The MDS also revealed PTSD as an active diagnosis and the use of antipsychotic medication.<br><br>A Trauma Evaluation assessment dated [DATE] revealed Resident #14 had a history of physical and sexual abuse. Triggers were listed as talking about the past.<br><br>A Care Plan dated 11/17/25 revealed Resident #14 had a self-care deficit related to PTSD. There were no triggers care planned that may impede self-care. Further review of the care plan revealed an update on 12/10/25. Resident #14 had a history of trauma with potential for re-traumatization related to past history of historical trauma and PTSD. There were no triggers listed in the care plan.<br><br>A psychiatric nurse practitioner note dated 11/12/25 revealed Resident #14 to have PTSD. There were no triggers listed in the note.<br><br>On 12/10/25 at 9:14 A.M., an interview with Certified Nurse Aide (CNA) #439 revealed she was unaware Resident #14 had PTSD or of any triggers that may upset him.<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 12/10/25 at 2:40 P.M., an interview with SSD #351 revealed the care plan For Resident #14 had been updated to indicate PTSD on 12/10/25 and it was based on Resident #14's trauma assessment. SSD #351 verified the Trauma assessment dated [DATE] had triggers listed on it that were not addressed. SSD #351 stated Resident #14 just got his voice back after having a tracheostomy so she could not know what potential triggers were.<br><br>Review of the facility's policy titled Care Planning – Interdisciplinary Team revised September 2013 stated the facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview and policy review the facility failed to ensure residents were assisted with activities of daily living including hair, nail and oral care. This affected three residents (Resident #30, #31 and #51) of 12 residents reviewed for activities of daily living. The census was 72.Findings include: 1. A review of the medical record for Resident #30 revealed a date of admission of 08/08/25. Significant diagnoses included urinary tract infection, need for assistance with personal care, and morbid obesity. Review of a care plan dated 08/08/25 revealed Resident #30 had a self-care deficit related to morbid obesity. Interventions included assisting with activities of daily living as needed.Review of a quarterly minimum data set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview of Mental Status (BIMS) score of 15 out of a possible 15, indicating intact cognition.Review of bathing documentation revealed no concerns. Staff were using bathing wipes during the facility water emergency (legionella) and had shower caps available for resident use. On 12/08/25 at 9:00 A.M. an observation of Resident #30 revealed them to be in bed. Resident #30 was noted to have oily hair that was uncombed and visible dirt noted under their fingernails.On 12/10/25 at 8:45 A.M. an observation of Resident #30 revealed their hair to be oily and their fingernails were dirty under the nails. Resident #30 stated their hair had not been washed for several weeks.On 12/10/25 at 9:00 A.M. Registered Nurse (RN) #418 verified the oily hair and dirty fingernails for Resident #30. The RN provided no additional information during the interview.On 12/30/25 at 3:00 P.M. an interview with Regional Director of Clinical Services (RDCS) #803 revealed the facility always has shampoo caps (a cap that is single use, premoistened with shampoo designed for waterless hair washing). RDCS #803 further stated the shampoo caps are stocked on each residential unit and in the supply room that all staff have the code for. An observation of the supply room at the time of the interview revealed approximately one-half case of shampoo caps. 2. A review of the medical record for Resident #31 revealed a date of admission of 09/05/25. Significant diagnoses included diabetes mellitus type two with foot ulcer, nonpressure chronic ulcer of the right foot, and need for assistance with personal care. Review of a care plan dated 09/05/25 revealed Resident #31 had a self-care deficit related to diabetes with foot wounds. Interventions included assistance with activities of daily living as needed.Review of a Medicare five-day minimum data set (MDS) assessment dated [DATE] revealed a BIMS of 14 out of a possible score of 15, indicating intact cognition. The MDS also revealed Resident #31 was a partial to moderate assistance for bathing.On 12/08/25 at 9:00 A.M. an observation of Resident #31 revealed them to be in a wheelchair. Resident #31 was noted to have oily hair that was not combed and visible dirt under their fingernails.On 12/10/25 at 8:45 A.M. an observation of Resident #31 revealed their hair to be oily and uncombed. Their fingernails were noted to be dirty. Resident #31 stated their hair had not been washed for at least two weeks. This was due to a water emergency in the facility.Review of bathing documentation revealed no concerns. Staff were using bathing wipes during the facility water emergency (legionella) and had shower caps available for resident use. On 12/10/25 at 9:00 A.M. Registered Nurse (RN) #418 verified the resident's oily and uncombed hair and dirty fingernails for Resident #31.On 12/30/25 at 3:00 P.M. an interview with Regional Director of Clinical Services (RDCS) #803 revealed the facility always has shampoo caps (a cap that is single use, premoistened with shampoo designed for waterless hair washing). RDCS #803 further stated the shampoo caps are stocked on each residential unit and in the supply room that all staff have the code for. An observation of the supply room at the time of the interview revealed approximately one-half case of shampoo caps. 3. A review of medical records for Resident #51 revealed a date of admission of 10/17/25. Significant diagnoses included chronic respiratory failure with hypoxia, morbid obesity due to excess calories, and need for assistance with personal care. Review of a care plan dated 10/17/25 revealed Resident #51 had a self-care deficit related to chronic respiratory failure and morbid obesity. Interventions included assistance with<br>(continued on next page) |

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|---|---|---|---|
| | 365539 | A. Building<br>B. Wing | 12/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Warren Nursing & Rehab | 2473 North Rd NE<br>Warren, OH 44483 |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | activities of daily living as needed.Review of the admission MDS assessment dated [DATE] revealed a BIMS of 15, indicating intact cognition. The MDS further revealed Resident #51 was a set up for oral care and dependent for all other activities of daily living. On 12/04/25 at 11:02 A.M. an observation of Resident #51 revealed them to be in bed. Resident #51 was tearful and stated they had just got a shower but their teeth had not been brushed since admission despite having oral care items available in their bathroom. Resident #51 was noted to have visible dirt under their fingernails. Licensed Practical Nurse #380 verified the dirt under Resident #51's fingernails at the time of the observation.On 12/16/25 at 3:00 P.M. observation and interview with Resident #51 revealed their teeth had still not been brushed. There was no toothbrush observed on Resident #51's bedside table. Resident #51 stated to look in the bathroom, and you will see my toothbrush that needs charged. One toothbrush that had dry bristles without signs of use was noted in the battery-operated toothbrush holder and two new toothbrushes were noted to be in a clear plastic, unopened covering. There was an unopened tube of toothpaste also observed. Social Worker Designee #351 verified the findings at the time of the observation.A review of the policy titled Activities of Daily Living (ADL), Supporting dated 03/24 revealed residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Appropriate care and services will be provided to residents who are unable to carry out activities of daily living independently with the consent of the resident and in accordance with the plan of care.This deficiency represents noncompliance investigated under Complaint Numbers 2687759, 2684242, 2641584, and 2655919. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a Magnetic Resonance Imaging (MRI) study was completed as ordered for Resident #80. This affected one resident (#80) reviewed for MRI follow-up. Also based on observation, record review and interview, the facility failed to ensure wounds received dressing orders and documented care. This affected one resident (Resident #18) of one resident observed for wound care of a surgical wound. The facility failed to ensure dressings were changed as ordered for one resident (Resident #28). The total census was 72.Finding include:1.Review of the medical record revealed Resident #80 was admitted to the facility on [DATE] with diagnoses including cervical disc disorder with myelopathy, high cervical region, spinal stenosis, cervical region, anemia, hyperkalemia, obesity, benign neoplasm of right ovary, type 2 diabetes mellitus with diabetic polyneuropathy, essential (primary) hypertension, acute respiratory failure with hypoxia, altered mental status, acute kidney failure, obstructive sleep apnea, metabolic encephalopathy, quadriplegia, c5-c7 incomplete, iron deficiency anemia, pain in right knee, vitamin d deficiency, muscle weakness, history of methicillin resistant staphylococcus aureus infection.<br><br>Review of the Minimum Data Set (MDS) 3.0 for Resident #80 dated 06/25/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS further revealed Resident #80 required set-up with eating, moderate assistance with oral hygiene, and maximum assistance to dependence with all other Activities of Daily Living (ADLs). No significant moods or behaviors were indicated in the MDS.<br><br>Review of Resident #80's medical record revealed an ultrasound of the pelvis on 03/14/24 that stated Impressions: large 11-centimeter suspicious right adnexal mass with recommendation for follow-up Magnetic Resonance Imaging (MRI) study. Further review of the Resident's medical record revealed an MRI was scheduled on three different occasions (05/15/25, 05/29/25 and 06/30/25) but no results or documentation about the MRI results were available in the medical record.<br><br>Interview with the Director of Nursing (DON) on 12/15/2025 at 2:50 PM confirmed the lack of documentation regarding the MRI results. The DON was also unable to confirm if the resident ever received the MRI as ordered or why it was rescheduled three times. The DON also stated she was unfamiliar with the facility's documentation policy.<br><br>Interviews on 12/30/25 between 3:00 P.M. and 3:11 P.M. with LPN #372, LPN #379, STNA #408 recall the resident and provided care to her in the past while she lived in the facility but do not recall her change in condition, ultrasound or her need for the MRI. Staff interviewed stated nurses are responsible for arranging appointments and transportation but do not recall whether the resident received the MRI as ordered or why the appointment was rescheduled three times.<br><br>Review of the facility's policy titled Charting and Documentation revised July 2023 revealed the medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.<br><br>2. Record review revealed Resident #18 was admitted [DATE] and had diagnoses including chronic respiratory failure, neurogenic bladder, and malnutrition. Review of their 12/23/25 wound assessment revealed they had a surgical wound on the coccyx measuring 4 centimeters (cm) by 1.5 cm with a depth of 0.4 cm. The assessment noted that the wound was sometimes identified as a pressure sore, however was currently defined as a surgical wound due to being covered by a skin graft. The (continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | assessment dated [DATE] measured the wound as 4 cm by 2 cm with a depth of 0.9 cm, and the assessment dated [DATE] measured the wound as 5 cm by 1.8 cm with a depth of 0.7 cm. Review of her facility assessments revealed she was admitted with a stage 2 pressure sore, the wound progressed to a stage 4 during a hospitalization in 07/2024, and a skin graft was placed on 12/31/24.<br><br>Record review of Resident #18's progress notes revealed she was hospitalized [DATE] for unresponsiveness and returned to the facility 11/05/25. Prior to this hospitalization, she had an order for wound care to the coccyx including Dakins-soaked gauze covered with an ABD pad twice daily. Wound care was not re-ordered following the hospitalization until 11/11/25, with no evidence of any dressing changes done from 11/05/25 to 11/11/25.<br><br>Interview with Wound Nurse #431 on 12/24/25 at 8:32 A.M. confirmed the above findings. She said it was the receiving nurse's responsibility to re-enter wound care orders and this was apparently not done.<br><br>3. A review of medical record revealed Resident #28 was admitted to the facility on [DATE] with diagnoses including peripheral vascular disease. Significant orders included Magic cup two times daily with lunch and dinner (nutritional supplement), house supplement two times daily, cleanse right and left calf with Hibiclens (antiseptic soap), rinse with normal saline pat dry, apply oil emulsion dressing and a pad and wrap with Kerlix gauze every day shift and as needed dated 12/16/25.<br><br>Review of the quarterly MDS 3.0 assessment dated [DATE] revealed a BIMS score of 15, indicating Resident #28 was cognitively intact. The MDS further revealed Resident #28 had no pressure areas and six arterial ulcers.<br><br>Review of the care plan dated 10/14/25 revealed Resident #28 had impairment of skin integrity related to vascular areas on admission. Interventions included consulting the wound care practitioner as needed and ordering and providing treatments as ordered.<br><br>On 12/17/25 at 12:01 P.M. an interview with CNP #820 revealed there were problems with the facility not doing dressings as ordered.<br><br>On 12/18/25 at 10:30 A.M. an observation of the bilateral lower extremity dressings for Resident #28 revealed them to be dated for 12/16/25. Licensed Practical Nurse (LPN) #843 verified the dates of 12/16/25 at the time of the observation. LPN #843 stated the dressings would have been dated for 12/17/25 if they had been done daily.<br><br>This deficiency represents noncompliance investigated under Complaint Number 2621765, 2647699, and 2621447. |

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|---|---|
| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide for the safe, appropriate administration of IV fluids for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to have interventions in place to maintain a peripherally inserted central catheter (PICC) line for Resident #31. This affected one resident (#31) of one resident reviewed for intravenous (IV) access and had the potential to affect three additional residents (#1, #2, and #25) identified by the facility with IV access. The facility census was 72.Findings include:A review of the medical record revealed Resident #31 was admitted to the facility on [DATE] and discharged on 12/12/25. Significant diagnoses included diabetes type two with a foot ulcer, local infection of the skin and subcutaneous tissue, and methicillin resistant staphylococcus aureus (MRSA) of unspecified site. Significant orders included de-clotting by thrombolytic agent of vascular access device or catheter dated 09/11/25, flush PICC line with 10 milliliters (ml) of 0.9 percent sodium chloride every day shift (09/06/25), replace PICC line (09/25/25), cathflo activase (a medication given through the PICC line to de-clot or clear an obstruction) use two milligram (mg) IV as needed for PICC line (09/10/25), and cefazolin (an antibiotic for infection) use two grams IV every eight hours for infection. There were no orders to monitor the PICC line for infection, change the PICC line dressing or to flush PICC line before and after medication administration.A review of Resident #31's medication administration record (MAR) dated 09/01/25 through 09/30/25 revealed no administration of cathflo activase.A care plan dated 09/05/25 revealed Resident #31 was on IV medications related to a wound infection. Interventions included monitoring for infection at the site and monitoring for signs of leaking. There were no interventions noted for routine care of the PICC line site.A progress note dated 09/09/25 at 11:46 P.M. revealed Resident #31 did not receive her antibiotics due to the PICC line being occluded.A progress note dated 09/10/25 at 5:02 A.M. revealed Resident #31 did not receive her antibiotic as the facility was waiting for PICC line replacement.Upon further review of the progress notes from 09/10/25 through discharge, 12/12/25, revealed no documentation as to when the PICC line was replaced or discontinued.A five-day Medicare Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating Resident #31 was cognitively intact.On 12/30/25 at 11:30 A.M. an interview with the Director of Nursing (DON) verified there were no orders for PICC maintenance or flushing after medication administration for Resident #31. A review of the facility policy titled Central Venous and Midline Catheter Flushing, dated 04/16, revealed catheters are to be flushed at regular intervals to maintain patency and before and after administration of intermittent solutions, administration of medications, obtaining blood samples and or converting from continuous to intermittent therapies.A review of the facility policy titled Central Venous Catheter Dressing Changes, dated 04/16, revealed dressings to central venous catheters are to be changed if it becomes damp, loosened or visibly soiled and at least every seven days.This deficiency represents noncompliance investigated under Master Complaint Number 2702276 and Complaint Number 2621447. |

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| | 365539 | A. Building<br>B. Wing | 12/31/2025 |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, facility policy review and review of the Centers for Disease Control and Prevention (CDC) website, the facility failed to provide tracheostomy care according to professional standards for Resident #22 and failed to date and/or change oxygen tubing weekly for Residents #29 and #67. This affected three residents (#22, #29 and #67) of eight residents reviewed for respiratory care. The facility census was 72.Findings include: 1. Review of the medical record for Resident #22 revealed an admission date of 07/25/24 and diagnoses including tracheostomy status, ventilator associated pneumonia, and chronic respiratory failure. The resident had a physician order dated 11/17/25 to receive tracheostomy care every shift and as needed.<br><br>Observation on 12/22/25 at 10:47 A.M. of tracheostomy care for Resident #22 by Licensed Practical Nurse (LPN) #341 revealed she used saline-moistened gauze to wipe at and around the tracheostomy tube and plate, then used another piece of gauze to dry it. No hydrogen peroxide or other appropriate disinfectant was used during the procedure.<br><br>Review of the facility tracheostomy care policy dated 08/2023 revealed hydrogen peroxide was to be used in the cleaning and disinfection of tracheostomies including site and stoma care.<br><br>Interview on 12/22/25 at 10:55 A.M. with LPN #341 confirmed no cleansing agent or disinfectant was used during the procedure. She stated staff only ever used saline for cleaning tracheostomies. Upon review of the facility's tracheostomy care policy, LPN #341 verified it indicated to use hydrogen peroxide.<br><br>Review of the CDC website section titled Recommendations for Disinfection and Sterilization in Healthcare Settings, dated 12/07/23, revealed high-level disinfection was to be provided for semi-critical patient care equipment including endotracheal tubes.<br><br>2. Review of the medical record for Resident #29 revealed an admission date of 12/09/22. Significant diagnoses included infection and inflammatory reaction due to cardiac and vascular devices, and acute and chronic respiratory failure. Physician orders effective December 2025 included oxygen as needed to keep oxygen saturations above 92 percent and to notify the physician if greater than six liters per minute (LPM) was needed. There were no orders noted for oxygen tubing maintenance.<br><br>Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #29 had no cognitive impairment.<br><br>Review of Resident #29's plan of care dated 10/22/25 revealed the resident was at risk for altered respiratory status related to chronic obstructive pulmonary disease and chronic respiratory failure. Interventions included oxygen as ordered.<br><br>Observation on 12/03/25 at 1:45 P.M. of Resident #29 revealed the resident in bed with oxygen being administered via nasal cannula (a tube in the nose that delivers oxygen). The oxygen tubing was not dated as to when it had last been changed. Interview at the time of the observation with Registered Nurse (RN) #431 verified the undated tubing.<br><br>3. Review of the medical record for Resident #67 revealed an admission date of 05/28/25. Significant diagnoses included traumatic subdural hemorrhage, acute and chronic respiratory failure, and<br>(continued on next page) |

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| | 365539 | A. Building<br>B. Wing | 12/31/2025 |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | tracheostomy status. Physician orders effective December 2025 included oxygen at one to ten LPM via mechanical breathing support for continuous inhalation to keep oxygen saturation at 92 percent or greater, and to change the oxygen tubing weekly.<br><br>Review of the quarterly MDS assessment dated [DATE] revealed Resident #67 had severe cognitive impairment, received oxygen therapy and had a tracheostomy.<br><br>Review of Resident #67's plan of care dated 12/29/25 revealed Resident #67 had oxygen use continuously via a tracheostomy as ordered.<br><br>Observation on 12/11/25 at 12:20 P.M. of Resident #67 revealed the resident in bed with oxygen being administered via mechanical breathing support. The oxygen tubing was dated as 11/26/25, which was greater than two weeks prior. Interview at the time of the observation with the Director of Nursing (DON) verified the date on the oxygen tubing as 11/26/25. The DON stated that oxygen tubing was to be changed weekly by respiratory therapy when a resident was on mechanical ventilation.<br><br>Interview on 12/30/25 at 4:08 P.M. with Respiratory Therapist #328 confirmed oxygen tubing was to be changed weekly. Residents who were on mechanical ventilation had tubing changed by respiratory therapy and residents who had nasal cannulas had tubing changed by floor nurses.<br><br>Review of facility policy entitled, Oxygen Administration, dated October 2022 revealed to change oxygen cannulas and tubing every seven days or as needed.<br><br>This deficiency represents noncompliance investigated under Complaint Number 2679591 and Complaint Number 2655919. |

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| F 0712<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that the resident and his/her doctor meet face-to-face at all required visits.<br><br>**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 residents were seen by a physician as required. This affected one resident (#69) of 15 residents reviewed for physician visits. The facility census was 72.Findings include: Review of the medical record for Resident #69 revealed an admission date of 09/24/24 with diagnosis that include cerebral infarction due to embolism of the left cerebellar artery, idiopathic aseptic necrosis of right humerus, severe protein-calorie malnutrition, aphasia, adult failure to thrive, gastrostomy, hyperosmolality and hypernatremia, hypothyroidism, acute kidney failure, hyperkalemia, and dehydration. Review of Resident #69's record revealed the resident was seen on 05/08/25 by Infectious Disease Doctor #809 for a urinary tract infections and on 09/07/25 by Medical Director #812 after resident had a fall. There were no other listed visits from a physician. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed resident did not have a Brief Interview for Mental Status (BIMS) score. Resident #69 had a memory problem, severely impaired cognitive skills, altered level of consciousness and was dependent on all activities of daily living, except for eating which she required setup assistance for. Interview on 12/10/25 at 10:23 A.M. with Nurse Practitioner (NP) #842 revealed Resident #69 had a history of malnutrition and her peg tube was removed in March 2025. NP #842 revealed she had not seen resident recently and had not heard any recent concerns from facility staff. Interview on 12/18/2025 at 2:52 P.M. with Licensed Practical Nurse (LPN) #424 confirmed Resident #69 had documented physician visits on 05/08/25 and 09/07/25. Interview on 12/30/2025 at 12:19 P.M. with Director of Nursing (DON) #452 revealed she did not know who is responsible for monitoring if residents are being seen every 60 days by physician. Interview on 12/30/2025 at 12:23 P.M. with [NAME] President of Clinical Services (VPCS) #806 revealed it was the previous Director of Nursing's responsibility to ensure residents are being seeing routinely by physician. Interview on 12/31/25 at 1:43 P.M. with Regional Director of Clinical Services #803 and VPCS #806 confirmed Resident #69 had not been seen by a physician since 09/07/25 and that it did not appear resident was being overseen by a physician. Review of the facility policy Physician Services with a revised date of April 2013 revealed physician visits, frequency of visits, emergency care of residents, etc., are provided in accordance with current regulations and facility policy. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, medical record review, and review of manufacturer instructions and facility policy, the facility failed to timely administer a physician ordered antibiotic for Resident #41 and correctly administer pen injected insulin for Resident #34 utilizing manufacturer instructions. This affected two residents (#34 and #41) out of two residents reviewed for medication administration. The facility identified 19 residents ( #1, #3, #5, #6, #17, #19, #21, #33, #34, #36, #44, #48, #50, #53, #57, #62, #63, #65 and #68) who received pen injected insulin. The facility census was 72.Findings include:1. Review of the medical record for Resident #34 revealed an admission date of 05/22/24 and diagnosis of diabetes mellitus type two. Physician orders effective December 2025 included an order for Toujeo solo star insulin 330 units (U) per milliliter (ml) solution pen injector, to inject 10 U subcutaneously every morning for diabetes mellitus. Review of the annual minimum data set (MDS) assessment dated [DATE] revealed a Resident #34 had moderate cognitive impairment, had diabetes mellitus type two, and received insulin injections daily over the seven-day lookback period. Review of the care plan dated 03/19/25 revealed Resident #34 had diabetes mellitus. Interventions included administering diabetes medication as ordered by the physician. Observation on 12/16/25 at 9:15 A.M. of insulin administration for Resident #34 with Licensed Practical Nurse (LPN) #323 revealed the nurse set the Toujeo insulin injector pen to 10 U and administered the medication but did not prime the injector pen prior to it being administered. Interview at the time of the observation with LPN #323 verified she did not prime the injector pen prior to administering the insulin. Review of the manufacturer instructions (packet insert) for the Toujeo insulin injector pen revealed the pen should be primed by setting the injector to three units and pushing the plunger prior to setting and administering the prescribed dose of the medication. Review of the facility policy entitled, Insulin Administration, dated September 2024 revealed the nursing staff had access to specific instructions (from the manufacturer if appropriate) on all forms of insulin delivery systems prior to their use.<br><br>2. Review of the medical record for Resident #41 revealed an admission date of 09/22/23 with diagnoses including moyamoya disease, chronic respiratory failure, transient ischemic attack (TIA), cerebral infarction, history of alcohol abuse, hypertension, and ventilator dependence.<br><br>Review of Resident #41's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment and was dependent on staff for assistance with all activities of daily living (ADLs) including medication administration.<br><br>Review of Resident #41's care plan initiated on 07/18/23 and last revised on 12/17/25 revealed the resident was at risk for infection. Goals and interventions included monitoring for signs and symptoms of infection and staff to follow standard precautions, including proper hand-washing techniques to minimize microorganism transmission. Additionally, there was a care plan related to a documented pressure ulcer initiated on 11/10/25. Goals and interventions included monitoring the wound for signs and symptoms of infection, if drainage was present obtain an order for culture, and provide wound care per treatment orders. The care plan was not updated to identify a wound infection or antibiotic orders.<br><br>Review of Resident #41's wound culture and sensitivity report completed on 11/12/25 due to signs and symptoms of infection including pus, redness, swelling, tenderness, and serous (a thin, watery, clear to pale yellow fluid) drainage revealed the wound culture result grew proteus mirabilis. The wound culture results were reported to the facility on [DATE] at 3:00 P.M.<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365539 | A. Building<br>B. Wing | 12/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Warren Nursing & Rehab | 2473 North Rd NE<br>Warren, OH 44483 |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #41's physician order dated 11/18/25 at 11:58 A.M. revealed RN #431 placed an order for Amoxicillin-Pot Clavulanate 875-125 milligram (mg) tablet, one tablet every 12 hours for 14 days for proteus mirabilis wound infection. Further review of the physician order revealed RN #431 entered the antibiotic to not begin until 11/19/25 at 7:00 P.M.<br><br>Interview on 12/30/25 at 4:30 P.M. with RN #431 revealed she spoke with Infectious Disease (ID) Physician #809 on 11/18/25 and reviewed the wound culture results with him and then received a verbal order for Amoxicillin-Pot Clavulanate 875-125 mg, one tablet every 12 hours for 14 days for proteus mirabilis wound infection. RN #431confirmed she entered the order for Resident #41's antibiotic on 11/18/25 at 11:58 A.M. and put it in to start the antibiotic on 11/19/25 at 7:00 P.M. When questioned why she put in the start date and time of 11/19/25 at 7:00 P.M., she stated she wanted to make sure there was enough time for the antibiotic to be delivered from the pharmacy. When questioned if the antibiotic was available in the facility's contingency box of medications provided by the pharmacy, she stated she did not look and just assumed it was not available. When questioned if she notified the physician of the start date and time of the antibiotic, she stated she did not notify the physician. When questioned what the facility protocol was when an order was given to start an antibiotic, she stated antibiotics should be started within hours of the order being given by the physician. When asked why she did not notify ID Physician #809 on 11/17/25 at 3:00 P.M. at the time when the wound culture and sensitivity results were reported to the facility, she stated it was the end of her day and thought it could wait until the next morning. RN #431 confirmed from the time the wound culture and sensitivity results were available until when the antibiotic was started, it was a total of 52 hours.<br><br>Interview on 12/31/25 at 11:10 A.M. with ID Physician #809 revealed he was unaware that Resident #41's wound culture and sensitivity results were reported to the facility on [DATE] at 3:00 P.M. and assumed when RN #431 reached out to him on 11/18/25 was when it was available. ID Physician #809 stated RN #431 should have notified him as soon as the results were available on 11/17/25 and not waited until 11/18/25. ID Physician #809 stated he was unaware RN #431 waited until 11/19/25 at 7:00 P.M. to start the antibiotic. ID Physician #809 stated it was unacceptable that a total of 21 hours had lapsed from the time the wound culture and sensitivity was reported to the facility until he was notified of results, and that another 31 hours had lapsed from the time the order for the antibiotic was given to the time the first dose was administered. ID Physician #809 stated that when he gives an order for antibiotics he expects them to be administered within hours. He stated this was why the pharmacy provided a contingency box with commonly used medications including antibiotics.<br><br>Interview on 12/31/25 at 11:30 P.M. with RN #431 confirmed Amoxicillin-Pot Clavulanate 875-125 mg was available in the facility's automated medication machine at the time ID Physician #809 gave the antibiotic order for Resident #41.<br><br>Review of facility's automated medication machine inventory list revealed there were five tablets of Amoxicillin-Pot Clavulanate 875-125 mg available for administration at time of the physician order for Resident #41 on 11/18/25.<br><br>Review of the facility policy entitled, Administering Medications, last revised April 2019, revealed all medications were to be administered in a safe and timely manner and as prescribed.<br><br>This deficiency represents noncompliance investigated under Complaint Number 2621765, Complaint Number 2621447, and Complaint Number 2688137. |

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| Warren Nursing & Rehab | 2473 North Rd NE<br>Warren, OH 44483 |

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| F 0773<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to obtain physician ordered laboratory testing. This affected three residents (#19, #27 and #57) out of three residents reviewed for laboratory testing. The facility census was 72.Findings include:1. Review of Resident #19's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses of type 2 diabetes mellitus with hyperglycemia, adult failure to thrive, homelessness, mood disorder, glaucoma, Guillain-Barre syndrome, obstructive sleep apnea and panic disorder.<br><br>Review of Resident #19's physician orders revealed an order dated 10/31/24 to obtain a Hemoglobin A1C (a blood test that measures the average blood sugar levels over the past two to three months that indicates the percentage of hemoglobin in the blood that is coated with sugar), a thyroid-stimulating hormone (TSH) level (a blood test that is used to check for thyroid gland problems), and Depakote level (measures the concentration of valproic acid in the blood to ensure therapeutic effectiveness and monitor for potential toxicity) every three months with no instructions for an end-date.<br><br>Additional review of Resident #19's medical record revealed no evidence of a Hemoglobin A1C or Depakote Level being completed after 08/05/2025 or a TSH level being completed after 08/07/25.<br><br>Review of the care plan dated 10/31/25 for Resident #19 revealed the resident was at risk for impairment of skin integrity due weakness, obesity and diabetes mellitus, and had potential for hypo/hyperglycemic episodes related to diabetes mellitus. Interventions included lab work monitoring and reporting any abnormal lab values to the physician.<br><br>Interview on 12/15/25 at 2:50 PM with the Director of Nursing (DON) confirmed Resident #19's Hemoglobin A1C, TSH and Depakote Level had not been drawn every three months as ordered by the physician.<br><br>2. Review of Resident #57's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses of acute respiratory failure with hypoxia, acute pulmonary edema, pneumonitis due to inhalation of food and vomit, hypo-osmolality and hyponatremia, sepsis, congestive heart failure (CHF), acute kidney failure, other abnormalities of breathing, Parkinson's disease with dyskinesia, long term (current) use of insulin, long term (current) use of anticoagulants, neurocognitive disorder with Lewy bodies, severe dementia with other behavioral disturbance, chronic kidney disease, type two diabetes mellitus with diabetic chronic kidney disease, atrial fibrillation, hyperlipidemia, diverticulitis, generalized anxiety disorder, gout, and depression.<br><br>Review of a physician's order dated 03/07/25 revealed an order to draw a complete blood count (CBC), complete metabolic panel (CMP), A1C, uric acid level, and TSH every three months in March, June, September and December with no instructions for an end date.<br><br>Additional review of Resident #57's medical record revealed no evidence of a CBC, CMP, A1C, uric acid level or TSH being completed after 06/10/25.<br><br>Review of Resident #57's care plan dated 05/04/25 revealed the resident had potential for impairment of skin integrity due to diabetes mellitus, weakness, and episodes of incontinence, and was at risk for (continued on next page) |

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|---|---|---|---|
| | 365539 | A. Building<br>B. Wing | 12/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Warren Nursing & Rehab | 2473 North Rd NE<br>Warren, OH 44483 |

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| F 0773<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | bleeding, bruising, and abnormal lab values related to use of an anticoagulant. Interventions included lab work monitoring and reporting any abnormal values to the physician.<br><br>Interview on 12/30/25 at 11:23 A.M. with the DON confirmed the CBC, CMP, A1C, uric acid level and TSH was not completed every three months as ordered by the physician.<br><br>3. Review of Resident #27's medical record revealed an admission date of 12/07/07, a significant diagnosis of diabetes mellitus type two, and current physician orders to obtain lab work for a Hemoglobin A1C quarterly (every three months).<br><br>Review of Resident #27's care plan dated 12/04/25 revealed the resident had potential for hypo/hyperglycemic episodes related to diabetes. Interventions included obtaining blood work as ordered and reporting any abnormal lab values to the physician.<br><br>Additional review of Resident #27's medical record revealed a Hemoglobin A1C test was completed on 03/10/25, 06/09/25 and 12/02/05. There was no test completed in September 2025.<br><br>Interview on 12/23/25 at 11:44 A.M. with Assistant Director of Nursing (ADON) #350 verified Resident #27 had no lab test completed in September 2025 as ordered. ADON #350 stated the floor nurses and she were responsible for tracking the labs, and there was no system in place for the tracking of labs due and being completed.<br><br>Interview on 12/30/25 at 4:26 P.M. with [NAME] President of Clinical Services #806 and Regional Director of Clinical Services #803 revealed there was no facility lab policy. The facility would just follow physician orders.<br><br>This deficiency represents noncompliance investigated under Complaint Numbers, 2695949, 2687759, and 2688137. |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or obtain dental services for each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff and family interviews, and facility policy review, the facility failed to provide timely dental services for Resident #6. This affected one resident (#6) of three residents reviewed for dental care. The facility census was 72.Findings include: Review of Resident #6's medical record revealed an admission date of 05/13/19 with diagnosis that include major depressive disorder, dementia, intracranial injury, essential hypertension, anxiety disorder, occlusion and stenosis of unspecified cerebral artery, alcohol dependence, and unspecified psychosis. Review of Resident #6's annual dental exam note dated 10/22/24 revealed the resident had an initial examination and was noted to have dentures. The initial exam noted Resident #6 was doing well with current dentures and the resident had no dental concerns. Review of the progress notes for Resident #6 revealed a note dated 12/17/24 authored by Social Service Designee (SSD) #351 which noted at the last care conference (date not specified) Resident #6's mother was concerned with his broken dentures. Dental services were notified. The note the last dental note from October 2024 noted the resident was doing well with his current dentures. The note indicated Resident #6's mother wanted staff to contact the dental company to check on the statement [that the resident was doing well with current dentures]. The note concluded with a statement that SSD #351 contacted the dental company via email. Continued review of Resident #6's progress notes revealed no follow up notes referencing Resident #6's dentures or dental status. Review of the care plan dated 11/12/25 revealed Resident #6 had full upper and lower dentures and staff should report any dental problems that need attention.Review of a nutrition assessment dated [DATE] revealed Resident #6 had dental full upper and lower dentures, with no chewing or swallowing concerns.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 did not have broken or loosely fitted full or partial dentures.Interview on 12/4/25 at 1:23 P.M. with Resident #6's mother revealed the resident's dentures were broken and she was concerned about him being able to eat. Interview on 12/4/25 at 4:14 P.M. with Licensed Practical Nurse (LPN) #424 revealed Resident #6 had dentures and had not mentioned anything to her about issues with eating. A follow up interview at 4:30 P.M. revealed LPN #424 checked Resident #6's mouth for his dentures and he did not have his dentures in his mouth. Resident #6 told LPN #424 he did not know where his dentures were. Interview and observation on 12/4/25 at 5:03 P.M. with Resident #6 said he has his own teeth. Resident opened his mouth and revealed he did not have his own teeth nor was he wearing any dentures. Interview on 12/11/25 at 2:38 P.M. with SSD #351 revealed Resident #6's dentures were broken and should be in his room. She revealed residents often refused dental visits. Interview on 12/15/25 at 12:55 P.M. with Certified Nursing Assistant (CNA) #404 revealed she checked Resident #6's mouth and he did not have his dentures in. CNA #404 checked Resident #6 room and was unable to find his dentures. CNA #404 revealed she did not know Resident #6 had dentures. Interview on 12/15/25 at 12:57 P.M. with LPN #316 revealed she had never seen Resident #6 with dentures in the past 10 years. Interview on 12/17/25 at 2:42 P.M. with SSD #351 revealed she called resident's mom and she did not have the information about resident's dentures. SSD #351 added Resident #6 to the list for the dentist to see next time they come to the facility for a routine visit to address the dentures which have been broken and/or missing for one year.Interview on 12/23/25 at 10:02 A.M. with Registered Dietitian (RD) #820 revealed she had been documenting the resident had dentures but was unaware the resident currently did not have dentures to wear. Review of facility policy titled Dental Services revised December 2023 revealed residents' dentures will be protected from loss or damage, to the extent practicable, while being stored. If dentures are damaged or lost, residents will be referred for dental services within 3 days. If the referral is not made within 3 days, documentation will be provided regarding what is being done to ensure that the resident is able to eat and drink adequately while awaiting the dental services; and the reason for the delay. |

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| | 365539 | A. Building<br>B. Wing | 12/31/2025 |

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|---|---|
| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview and review of facility policy, the facility failed to accomodate Resident #27's food preference as requested by the resident. This affected one resident (#27) of two residents reviewed for food choices. The facility census was 72. Findings include:Review of medical records for Resident #27 revealed an admission date of 01/14/25 with significant diagnoses including peripheral vascular disease, chronic obstructive pulmonary disease and dysphagia (difficulty swallowing). Significant orders included Regular diet with mechanical soft texture, magic cup two times daily with lunch and dinner, and health supplement two times daily.A review of a quarterly minimum data set assessment dated [DATE] revealed Resident #27 had no cognitive impairment.A review of a care plan dated 10/14/25 revealed Resident #27 had potential for alteration in nutrition and hydration related to peripheral vascular disease and dysphasia. Interventions included food in separate bowls per resident request, monitor and document and report signs and symptoms of dysphasia such as holding food in mouth, and provide and serve diet as ordered.On 12/11/25 at 12:30 P.M. an observation of the lunch tray for Resident #27 revealed he had ordered peaches for lunch on an at- your-request menu. Peaches was written on the menu. Resident #27 had diced pears on the tray. Resident #27 stated he ordered peaches because he was unable to chew other fruit. Therapy Director #359 was present at the time of the observation and verified Resident #27 had diced pears on the tray, but had ordered peaches.On 12/11/25 at 2:00 P.M. an interview with Dietary Manager (DM) #317 revealed the kitchen will not open a can of peaches for one resident so Resident #27 did not get peaches for lunch. On 12/23/25 at 10:03 A.M. an interview with Registered Dietician (RD) #820 revealed she was unaware of Resident #27 not receiving requested menu items. RD #820 stated a resident's reasonable dietary requests should be honored. RD #820 stated peaches should have been given to Resident #27. Review of the policy titled Resident Food Preferences, dated 07/17, revealed individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. Modifications to the diet will only be ordered with the resident consent. If the request for the food items are beyond the scope of the community or not within budget constraints of the community the residents should be informed. The food service department will offer food choices at each scheduled meal as well as access to nursing snacks throughout the day and night. The facilities quality assessment and performance improvement committee will periodically review issues related to food preferences and meals to try and identify more widespread concerns about meal offerings, food preparation, etcetera. |

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|---|---|
| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of facility policy, the facility failed to ensure a complete and accurate medical record for Resident #80. This affected one resident (#80) of 53 residents reviewed for the annual survey. The facility census was 72.Findings include:Review of the medical record revealed Resident #80 was admitted to the facility on [DATE] with diagnoses including cervical disc disorder with myelopathy, high cervical region, spinal stenosis, cervical region, anemia, hyperkalemia, obesity, benign neoplasm of right ovary, type 2 diabetes mellitus with diabetic polyneuropathy, essential (primary) hypertension, acute respiratory failure with hypoxia, altered mental status, acute kidney failure, obstructive sleep apnea, metabolic encephalopathy, quadriplegia, iron deficiency anemia, pain in right knee, vitamin D deficiency, muscle weakness, history of methicillin resistant staphylococcus aureus infection.Review of the Minimum Data Set (MDS) 3.0 assessment for Resident #80 dated 06/25/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS further revealed Resident #80 required set-up with eating, moderate assistance with oral hygiene, and maximum assistance to dependence with all other activities of daily living (ADLs). No significant moods or behaviors were indicated in the MDS.Review of Resident #80's medical record revealed an ultrasound of the pelvis on 03/14/24 that stated Impressions: large 11-centimeter suspicious right adnexal mass with recommendation for follow-up Magnetic Resonance Imaging (MRI) study. Further review of the Resident's medical record revealed an MRI was scheduled on three different occasions (05/15/25, 05/29/25 and 06/30/25) but no results or documentation about the MRI results were available in the medical record for review during the time of the survey.Review of the nursing progress notes in Resident #80's medical record revealed a note on 04/29/25 at 4:49 P.M. authored by Licensed Practical Nurse (LPN) #372 that revealed the resident stated she was not feeling right, blood pressure was checked and was 174/101, the pulse was 88. The nurse notified the physician and received a new order for a one-time dose of 0.25 (milligrams (mg)) of Catapress and to resume blood pressure (BP) medications: Amlodipine 10 mg in the morning and Lisinopril 20 mg at bedtime. No additional follow-up or communication with the physician was documented regarding this incident with the resident's blood pressure until the resident's vital signs were documented again on 05/16/25.Interview with the Director of Nursing (DON) on 12/15/2025 at 2:50 P.M. confirmed the lapse in charting or the lack of follow up documentation. The DON was also unable to confirm if the resident ever received the MRI as ordered or why it was rescheduled three times. The DON also stated she was unfamiliar with the facility's documentation policy.Interview on 12/30/25 at 3:00 P.M. with LPN #372 revealed she was able to recall Resident #80 and stated she provided care to her in the past while she lived in the facility, but did not recall her change in condition, ultrasound, or her need for the MRI. She stated nurses were responsible for arranging appointments and transportation but did not recall whether the resident received the MRI as ordered or why the appointment was rescheduled three times.Review of the facility's policy titled Charting and Documentation revised July 2023 revealed the medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.This deficiency represents noncompliance investigated under Complaint Number 2695949, Complaint Number 2614520, Complaint Number 2621447 and Complaint Number 2679591, and Complaint Number 2655919. |