

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/13/2026
NAME OF PROVIDER OR SUPPLIER Rolling Hills Rehab and Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 68222 Commercial Drive Bridgeport, OH 43912	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, review of facility temperature logs, and facility policies, the facility failed to safely store drugs at proper temperatures to preserve their integrity. Further, the facility failed to properly ensure controlled medications were stored in a separately locked, permanently affixed compartment. This affected four residents (Resident #13, 19, 25, and 42), and had the potential to affect all residents of the facility due to stock medications. Findings include: An observation of the North Medication Room on 07/08/26 from 7:06 A.M. to 7:45 A.M. revealed a medication refrigerator with a temperature of 50 degrees Fahrenheit. The refrigerator held resident medications and stock medications which could be used for any resident if ordered. There were two thermometers within the refrigerator confirming the temperature. All observations were confirmed by the Director of Nursing (DON) at the time of the observation. Medications stored in the refrigerator which affected specific residents included the following: a. Resident #13 had two Lantus Solostar Pens (insulin). Instructions for the medication were to store unopened in the refrigerator from 36 degrees Fahrenheit (F) to 46 degrees F until first use. Resident #13 also had Insulin Lispro Injection (10 milliliter (ml) vial). Instructions for the Insulin Lispro were to store unopened in the refrigerator at 36 degrees F to 46 degrees F until the expiration date. b. Resident #19 had four Lantus Solostar Pens. Instructions for the medication were to store unopened in the refrigerator from 36 degrees F to 46 degrees F until first use. c. Resident #25 had Insulin Glargine. Instructions for the medication were to store unopened in the refrigerator from 36 degrees F to 46 degrees F until expiration date or until first use. She also had a Pneumovax injection. The instructions for storage of the Pneumovax were to store refrigerated at 36 degrees F to 46 degrees F. Resident #25 had 13 Trulicity injection pens. Storage instructions were to store in the original carton at 36 degrees F to 46 degrees F. d. Resident #42 had two Novolog FlexPens in the refrigerator. Instructions for storage were to store unopened in the refrigerator from 36 degrees F to 46 degrees F until first use. The refrigerator also had medications indicated for stock use, which were medications which could be used for any resident in the event the physician ordered it and it was not immediately available to the resident or while waiting on the pharmacy to send the ordered medication to the facility. Stock medications which required storage at 36 degrees F to 46 degrees F included: Two Cathflo Activase; One Lorazepam Concentrate; One vial of Novolin N; Four Promethazine suppositories; One Lispro Vial; One Novolin R vial, One Novolin vial; Three Basaglar KwikPens; an one Lantus Solostar. There was a Tuberculin Purified Protein vial which was to be stored at 35 degrees F to 46 degrees F. The Lorazepam Concentrate 30ml was in a clear plastic box inside the medication refrigerator. The box had a lock on it; however, the lock was broken and the lid was not secured. The refrigerator was not locked. This was confirmed by the DON at the time of the observation. On 07/08/26 at 7:42 A.M., an interview with the DON revealed Lorazepam should be (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	locked at all times due to being a controlled substance. She confirmed the box the Lorazepam concentrate was stored in was not locked or secured inside the medication refrigerator. She further confirmed all of the medications were to be stored at temperatures of 46 degrees F or below and the temperature in the medication refrigerator was 50 degrees F. Review of facility temperature log for July 2026 for the North medication refrigerator revealed temperatures on 07/07/26 with no time indicated. The temperature was 40 degrees F. Temperature on 07/08/26 (no time indicated) was listed as 40 degrees F. This log was confirmed by DON at 7:53 A.M. Review of a facility policy titled Storage of Medications, Revised April 2007, revealed the facility would store all drugs and biologicals in a safe, secure, and orderly manner. The nursing staff would be responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner. Medications requiring refrigeration must be stored in a refrigerator located in the drug room located at the nurse's station or other secured location. Medications must be stored separately from food and must be labeled accordingly. Review of a facility policy titled Controlled Substances, revised December 2012, revealed the facility would comply with all laws, regulations, and other requirements related to handling, storage, disposal and documentation of schedule two and other controlled substances. Controlled substances must be stored in the medication room in a locked container, separate from containers for any non-controlled medications. The container must remained locked at all times, except when accessed to obtain medication for a resident.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on review of facility infection control logbook, review facility policy, and interview with the facility infection preventionist, the facility failed to maintain standardized surveillance of its antibiotic stewardship program. This had the potential to affect 52 residents residing in the facility. The facility census was 52. Findings Include: Review of the infection control logbook from January 2026 to July 2026 revealed a monthly log sheet containing a list of residents with infections, type of infection, type of organism if available, treatment ordered and completed, and available laboratory data. Further review of the logbook revealed blank copies of the McGeer's infection surveillance tool in the back of the logbook. There was no evidence of the McGeer's tool being filled out for any of the residents listed as having infections to ensure antibiotics prescribed were appropriate for the resident. The McGeer's criteria for infection surveillance tool is a standardized and nationally accepted tool used by health care facilities to establish standard definitions and criteria for infections and determine if residents meet the criteria to receive antibiotic therapy. The use of McGeer's tool is to assist facilities in preventing the overuse or unnecessary use of antibiotic therapy. Interview on 07/13/26 at 4:30 P.M. with the facility infection preventionist and assistant director of nursing (ADON) #700 revealed she did not have evidence of McGeer's being completed on each resident with a suspected infection and that she reviewed the criteria for infection following the McGeer's but did not actually complete the tool for each resident. ADON #700 verified since there was no evidence of the completion of the McGeer's for each individual resident with an infection it would be difficult to determine compliance with the antibiotic stewardship program. Review of the facility policy titled, Antibiotic Stewardship -Orders for Antibiotics, and revised 12/2016 revealed, appropriate indications for use of antibiotics include criteria met for clinical definition of active infection. Further review of Infection Prevention and Control Program section #8 (Antibiotic Stewardship), revised 10/2018 revealed, medical criteria and standardized definitions of infections are used to help recognize and manage infection. Antibiotic usage is evaluated and practitioners are provided feedback on review.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on review of medical records, review of facility policies, and interviews with facility staff, the facility failed to provide a comprehensive immunization program to ensure residents are offered and received immunizations timely. This affected four (Residents #9, #10, #20, and #26) of five residents reviewed for immunizations. The facility census was 52. Findings Include; 1. Review of Resident #9 medical record revealed admission to facility on 11/05/19 for diagnoses including toxic encephalopathy (water on the brain), major depressive disorder, anemia (low blood count), dementia (confusion and forgetfulness), anxiety disorder, heart disease and high blood pressure. Further review of the medical record for Resident #9 revealed vaccination consents for the influenza vaccine, pneumonia vaccine, and covid-19 vaccine were dated for 05/12/26. 2. Review of Resident #10 medical record revealed admission to facility on 01/28/26 for diagnoses including alcoholic cirrhosis (liver damage), lung disease, diabetes, encephalopathy (water on the brain), anxiety, dementia, depression, heart failure, and kidney disease. Further review of the medical record for Resident #10 revealed vaccination consents for the influenza vaccine, pneumonia vaccine, and covid-19 vaccine were dated for 05/13/26. 3. Review of Resident #20 medical record revealed admission to facility on 10/03/25 for diagnosis including cellulitis of neck (infection of the skin), stroke with paralysis of one side, aphasia (inability to speak), high blood pressure, heart disease, and Alzheimer's disease (progressive confusion and forgetfulness). Further review of the medical record for Resident #20 revealed vaccination consents for the influenza vaccine, pneumonia vaccine, and covid-19 vaccine were dated for 06/11/26. 4. Review of the medical record for Resident #26 revealed admission to the facility on [DATE] for diagnoses including chronic respiratory failure, lung disease, diabetes, high blood pressure, depression, anxiety, heart disease, atrial fibrillation (irregular heartbeat), gastric reflux, schizoaffective disorder (paranoid personality tendencies), and poor circulation in legs. Further review of the medical record for Resident #26 revealed vaccination consents for the influenza vaccine, pneumonia vaccine, and covid-19 vaccine were dated for 05/11/26. Interview on 07/13/26 at 10:57 A.M. with Director of Nursing (DON) revealed that she had found concerns with vaccine administration of residents shortly after starting her position on 02/27/26. The DON confirmed the consents were not obtained timely for Residents #9, #10, #20, and #26 and there was no evidence of those residents receiving the vaccinations in their medical records prior. The DON further reported that the facility immediately began a quality assurance performance improvement (QAPI) project upon discovery of the concerns to correct the situation and that ongoing monitoring continues. Review of the facility policy titled, Vaccination of Residents, and revised on 10/2016 revealed all residents will be offered vaccines that aide in preventing infectious disease and all new residents shall be assessed for current vaccination status on admission and receive education regarding benefits and side effects of vaccines provided by the facility and if they consent or decline them. The deficient practice was corrected on 006/25/26 when the facility implemented the following corrective actions. The QAPI plan dated 04/06/26 revealed the responsible party for completion of the plan was the DON. The plan included whole house audit and immunization updates, education to nursing staff entering immunizations not the computer, and scanning consents into computer upon admission. The QAPI plan further revealed a resolved dated of 06/25/26. Facility wide chart audits of all residents' vaccination status were reviewed by the DON on 04/26/26 reviewing resident records from 10/01/25 through 04/30/26. Ongoing weekly audits by the (continued on next page)		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DON for all new admissions to the facility to ensure consents for vaccinations were completed and immunizations were entered in the medical records began on 05/11/26 and continued through 07/08/26 per the weekly audit tool verified. On 05/12/26 nursing staff including all LPNs and RNs were educated by the DON both verbally and in writing about obtaining vaccination status on all new admissions, completing consents for immunizations on admission an annually and entering into the vaccination status in the medical record. Staff sign-in sheets for education and training were verified. Review of the entire facility immunization report provided by the DON for Covid-19 vaccine and applicable boosters, influenza vaccine, and the pneumonia vaccines revealed all current residents vaccination status were updated in the electronic medical record.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm 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. Based on medical record review, policy review, and interview, the facility failed to notify a resident's representative of severe weight loss. This affected one (Resident #50) of three residents whose responsible parties were interviewed. Findings include: Review of Resident #50's medical record revealed diagnoses including Alzheimer's disease, stroke, type two diabetes, difficulty swallowing, depression, heart disease, and dementia with agitation. Review of a plan of care initiated 04/30/26 indicated Resident #50 had a nutritional problem related to decreased oral intake, therapeutic diet and mechanically altered diet. Interventions included monitoring intake and record every meal and monitor for significant weight loss. A weight of 203.9 pounds was recorded on 05/19/26. A weight of 193.4 pounds was recorded on 05/26/26, representing a 5.15% weight loss in one week. There was no documentation revealing Resident #50's responsible party was notified of the significant weight loss. Review of the facility's Nutrition (Impaired)/Unplanned Weight Loss-Clinical Protocol (revised September 2012) revealed nursing staff were responsible for monitoring and documenting weights and dietary intake of residents in a format which permitted readily available comparisons over time. The protocol revealed a weight loss of greater than 5% within one month was identified as a severe weight loss. Review of the facility's Change in a Resident's Condition or Status policy (revised December 2016) described a significant change of condition as a major decline or improvement in the resident's status that would not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, impacted more than one area of the resident's health status, required interdisciplinary review and/or revision to the care plan and ultimately was based on the judgment of the clinical staff. Unless otherwise instructed by the resident, a nurse would notify the resident's representative when there was a significant change in the resident's physical status. Except in medical emergencies, notifications would be made within 24 hours of a change occurring in the resident's condition. If a significant change in the resident's physical or mental condition occurred, a comprehensive assessment of the resident's condition would be conducted. On 07/09/26 at 6:00 P.M., the Director of Nursing (DON) verified she could not find documentation of the responsible party being notified of Resident #50's severe weight loss in May 2026.		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to timely complete a significant change assessment for a resident who exhibited a severe weight loss and developed pressure ulcers since their prior assessment. This affected one (Resident #50) of 17 residents whose minimum data set (MDS) assessments and clinical records were reviewed for significant changes in condition. Findings include: Review of Resident #50's medical record revealed diagnoses including Alzheimer's disease, stroke, type two diabetes, difficulty swallowing, depression, heart disease, and dementia with agitation. An admission/Medicare five day MDS assessment dated [DATE] indicated Resident #50 was severely cognitively impaired. Resident #50 was assessed with no or unknown significant weight changes and had no unhealed pressure ulcers. A weight of 203.9 pounds was recorded on 05/19/26. A weight of 193.4 pounds was recorded on 05/26/26, representing a 5.15% weight loss in one week. Review of Resident #50's weekly wound observation dated 05/25/26 indicated Resident #50 had acquired a stage III pressure ulcer (full thickness skin injury that extends into the subcutaneous tissue) on bilateral buttocks. Review of the Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.20.1, revealed a significant change assessment should be completed by the 14th calendar day after the facility determined a significant change in the resident's status occurred. A significant change was described as a major decline or improvement in a resident's status that would not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, impacted more than one area of the resident's health status and required interdisciplinary review and/or revision of the care plan. During an interview on 07/10/26 at 11:12 A.M., Assistant Director of Nursing (ADON) #700 stated she was unaware of any Interdisciplinary Team (IDT) discussions to determine if Resident #50 should have a Significant Change MDS completed prior to initiation of hospice in July 2026.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation and interviews with residents, and interviews with staff, the facility failed to provide activities of interest for Resident #26 and Resident #50. This affected two (Residents #26 and #50) of two residents reviewed for activities. The facility census was 52. Findings Include: 1. Review of the medical record for Resident #26 revealed admission to the facility on [DATE] for diagnoses including lung disease, diabetes, depression, anxiety, atrial fibrillation (irregular heartbeat), schizoaffective disorder (paranoid personality tendencies), and poor circulation in legs. Further review of most recent (MDS) 3.0 annual comprehensive assessment completed on 08/13/25 for Resident #26 revealed that it was very important to the resident to go outside and get fresh air when the weather was good and very important for Resident #26 do things with groups of people. Review of the activities care plan dated 04/30/26 for Resident #26 revealed she was dependent on staff for meeting emotional, intellectual, and social needs and the resident would participate in activities of choice. Further review of the care plan for Resident #26 revealed interventions to invite the resident to scheduled activities and assist/escort resident to activities. Review of the most recent minimum data set (MDS) 3.0 quarterly assessment completed on 06/01/26 for Resident #26 revealed a brief interview for mental status (BIMS) score of 14/15 indicating cognitively intact. Resident #26 was noted to be dependent in a wheelchair for mobility and required partial to moderate assistance with personal care, dressing, and bathing. Review of the activity calendar for July 2026 revealed an outing planned on 07/03/26 for fireworks in the area. Observation and interview on 07/06/26 at 1:00 P.M. revealed she had concerns with the activities department and that the activities director (AD) #749 had stopped by her room last week and was in a hurry and asked her if she would want to go on the outing to watch fireworks. Resident #26 reported she told him yes and he added her name to the list and hurried off. On Friday 07/03/26, the day of the fireworks outing, Resident #26 reported she went to get on the van, and she was told by the AD #749 that her name was not on the list and she could not go. Resident #26 reported she was very disappointed especially because she found that they had stopped by the casino during the outing and even though she didn't have any money for the casino she would have liked to have gone to that also. Resident #26 reported she was still upset and disappointed about not going to the event. It was noted that the fire work show/outing was to celebrate the 250th anniversary of American Independence Day. Interview on 07/07/26 at 11:32 A.M. with the AD #749 revealed he had been with the facility for approximately two months and he was responsible for managing the activities program and developing the monthly activities calendar and events. (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued interview with AD #749 revealed the facility had a van for transporting residents to scheduled outings and that the activities department was responsible for driving the van. AD #749 reported that, if necessary, the facility would make multiple trips with the van if numerous residents wanted to attend a specific outing. AD #749 confirmed that a resident would not be told they could not attend an outing based on room for transportation and that even if one additional resident would want to go on an outing an additional trip would be made to ensure all residents who wanted to participate in the outing were able. Interview on 07/07/26 at 11:36 A.M. with the facility Administrator revealed the facility had a fourth of July celebration that included an outing for fireworks on 07/03/26. The facility had a van that could be used to take residents to and from outings and would hold up to two residents with wheelchairs, two residents without wheelchairs in the back and one additional resident in the passenger seat in the front of van for a total of five residents being able to be transported at a time. Further interview on 07/07/26 at 2:00P.M. with the AD #749 revealed that Resident #26 approached him while loading residents into the facility van for the outing to the fireworks on 07/03/26. AD #749 reported that Resident #26 asked to go to the fireworks show and he told her she could not go in what she was wearing, a night gown and slippers, and needed to go back and change her clothes. AD #749 reported, at that time, Resident #26 refused to change her clothes and was going to go in her current attire. AD #749 further reported that he did not offer to assist the Resident #26 or ask any nursing staff to assist Resident #26 with changing her clothes. AD #749 reported that he could not recall the specifics of the clothing other than it was a blue night gown looking attire and did admit there was no indecent exposure of Resident #26 in the gown. Interview on 07/07/26 at 2:13 P.M. with the activities assistant (AA) #727 revealed she was present on 07/03/26 assisting residents into the facility van for transportation to the fireworks and did recall the AD #749 talking with Resident #26 but did not hear their conversation. AA #727 further expressed that Resident #26 had a blue gown with white flowers on it that day from her recollection. AA #727 reported that Resident #26 did not get on the van and go to the fireworks but had no knowledge of why Resident #26 did not go. Review of the attendance roster for the firework outing on 07/03/26 revealed five residents signed up for the event, Residents #6, #9, #17, #32 and #36. Of those five only three residents went on the outing, Residents #6, #32, and #36. It was noted that Resident #26 was not on the list and that only three residents were on the van that had the capacity to seat up to five residents. The document was produced and verified by AD #749 who verified there was room for additional residents to board the van to go to the fireworks. 2. Review of Resident #50's medical record revealed diagnoses including Alzheimer's disease, stroke, type two diabetes, difficulty swallowing, depression, heart disease, and dementia with agitation. An initial activities assessment dated [DATE] indicated Resident #50 did not want to talk and would be assessed at a later time. The only current activity participation listed was independent activities. Everything else was marked unknown with the exception of an entry indicating Resident #50 did not wish to have visits by clergy. (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Activity Interview of Daily and Activity Preferences form dated 04/28/26 indicated it was somewhat important for Resident #50 to keep up with the news. Staff assessment of daily and activity preferences indicated preferences of reading materials, listening to music, and keeping up with the news. Review of a plan of care initiated 05/19/26 revealed Resident #50 had little or no activity involvement related to physical limitations. Interventions included reminding Resident #50 he could leave activities at any time. The care plan indicated Resident #50 needed a variety of activity types and locations to maintain interests. Observation of Resident #50 on 07/06/26 at 1:52 P.M., 1:54 P.M. and 4:30 P.M. revealed Resident #50's door was shut. The only interaction or stimuli noted was when a nurse responded to calling out and offered water. On 07/07/26 at 4:38 P.M., observations revealed Resident #50's door was closed and he was lying in bed with his eyes closed. No external stimulation/activity was provided. On 07/08/26 at 8:40 A.M., 10:45 A.M., 10:47 A.M., 10:48 A.M. and 10:53 A.M. Resident #50's door was closed and he was calling out. No activities were observed offered/provided. On 07/08/26 at 1:14 P.M., Resident #50's door was closed and he was lying in bed with his eyes closed with no external stimulation noted. On 07/08/26 at 5:05 P.M. Resident #50's door was shut and he occasionally moaned out. No activity or external stimulation was observed. Review of an Activity Interview of Daily and Activity Preferences form dated 07/07/26 indicated the same interests as the assessment on 04/28/26. Review of activity participation logs between 06/09/26 and 07/08/26 revealed a room visit was provided on 07/06/26. The remainder of the activity log was blank with no refusals recorded. During an interview on 07/08/26 at 10:55 A.M., Certified Nursing Assistant (CNA) #737 stated staff Resident #50 usually refused to get out of bed. Resident #50 sometimes enjoyed watching television and would ask for it to be turned on. During an interview on 07/08/26 at 2:13 P.M., Activity Director #749 stated all activity participation records were kept in the electronic health record. During an interview on 07/08/26 at 5:27 P.M., Activity Assistant #727 stated she had worked at the facility for six weeks. When she started working, she had done a couple (estimated two times) one on one visits with Resident #50. After she worked her first five days, a new activity director (Activity Director #749) started and she was not provided much direction after that. The activity department's focus was on providing transport for residents and providing activities to those residents who went to the activity room. On 07/09/26 at 7:47 A.M., the Director of Nursing (DON) provided paper activity logs for June 2026 and July 2026. Television was marked every day. The June log indicated Resident #50 had visitors and pet visits on 06/12/26 and refused newspaper on 06/13/26. One refusal of an off-site outing was recorded on 07/03/26. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Rolling Hills Rehab and Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 68222 Commercial Drive Bridgeport, OH 43912	
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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview of Activity Director #749 on 07/09/26 at 8:02 A.M., with the Administrator present, revealed he verified activity documentation was supposed to be completed in the electronic health record as previously stated. Activity Director #749 stated he was told to provide activity records so he filled out paper logs trying to rely on his memory. Activity Director #749 verified he could not confirm the records were 100% accurate. Observations and other interviews were discussed regarding the use of the television and the door being shut with every observation and if he entered Resident #50's room every day to ensure the television was on/playing. Activity Director #749 stated he has walked past Resident #50's room in the past and seen the television on.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, medical record review, policy review and interview, the facility failed to ensure residents who smoked did so at scheduled times and in designated smoking areas. This affected one (Resident #13) of two residents screened for smoking. The facility identified 14 residents who smoked. Findings include: Review of Resident #13's medical record revealed diagnoses including type two diabetes mellitus, generalized muscle weakness, major depressive disorder, anxiety disorder and nicotine dependence. Resident #13 originally signed the smoking policy on 04/23/26. On 04/24/26, a physician's order was written indicating smoking was allowed with direct observation by staff in accordance with facility safety policy. Review of Resident #13's most recent smoking-safety screen dated 04/26/26 indicated Resident #50 required supervision and needed the facility to store the lighter and cigarettes. Smoking was allowed with direct observation by staff in accordance with the facility policy. A care plan initiated 05/01/26 indicated Resident #13 was a smoker. Interventions included instructing Resident #13 about the smoking policy including locations, times and safety concerns. Also included were instruction to notify the charge nurse immediately if it was suspected Resident #13 had violated facility smoking policy and that Resident #13 required supervision while smoking. On 07/06/26 at 8:20 A.M., Resident #13 was observed sitting in his motorized scooter smoking in the parking lot unsupervised. On 07/07/26 at 8:32 A.M., Resident #13 was observed smoking in the parking lot. Business Office Manager (BOM) #741 verified Resident #13 were smoking unsupervised. On 07/07/26 at 9:02 A.M., BOM #741 stated it was common for Resident #13 to sign out of the facility and go to the corner of the property to smoke. BOM #741 verified there was no supervision provided when Resident #13 signed out of the facility to smoke. BOM #741 verified the area where Resident #13 was observed smoking at 8:32 A.M. was on the facility grounds and did not contain a smoking receptacle. Review of Resident #13's sign out sheet revealed he had not signed out on 07/06/26. During an interview on 07/07/26 at 9:17 A.M., Licensed Practical Nurse (LPN) #734 stated Resident #13 had a history of non-compliance with the facility's smoking policy and consistently would not return his cigarettes. When Resident #13 signed out he was supposed to leave the facility grounds but she was uncertain where he went to smoke upon signing out. On 07/07/26 at 9:30 A.M., the Administrator stated residents were supposed to sign out of the facility if they were leaving to smoke if they were not going to accept supervision. However, he did not believe it was safe for residents to leave the facility's grounds. The Administrator was informed of two surveyors observing Resident #13 smoking on facility grounds outside the facility smoking times and designated smoking areas without signing out on 07/06/26. The Administrator stated he would review the smoking policy with Resident #13 again and if he remained non-compliant would have to issue a 30 day notice. Review of the facility's Smoking Policy_Residents (revised December 2016) revealed prior to, and upon admission, residents would be informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility could accommodate their smoking or non-smoking preferences. Smoking was only permitted in designated smoking areas, which were located outside of the building. Smoking was only permitted during designated smoking times (listed smoking times which were updated at 9:00 A.M., 12:00 P.M., 2:30 P.M., 6:15 P.M. and 9:00 P.M.) Residents would be evaluated upon admission to determine if he or she was a smoker or non-smoker. If a smoker, the evaluation would include current level of tobacco consumption, method of tobacco consumption, desire to quit smoking and ability to smoke safely with or without supervision. The staff was to consult with the attending physician and the Director of Nursing (DON) to determine if safety (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	restrictions needed to be placed on a resident's smoking privileges based on the Safe Smoking Evaluation. A resident's ability to smoke safely would be re-evaluated quarterly, upon a significant change and as determined by staff. Any smoking-related privileges and restrictions were to be noted on the plan of care. Any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff member, at all times while smoking. Residents were not permitted to keep cigarettes or other smoking articles in their possession. Only disposable safety lighters were permitted.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and review of drug information the facility failed to observe residents administer their respiratory inhalers and failed to ensure residents rinsed their mouth after using a steroidal inhaler. This affected one resident (Resident #10) of three residents reviewed for medication administration. Findings include: On 07/08/26 at 8:20 A.M., Licensed Practical Nurse #715 handed Resident #10 a fluticasone furoate (Arnuity) inhaler, then turned her back to resident without observing the resident take the medication. The resident properly administered one puff of the inhaler, however she did not rinse her mouth with water following the medication administration. The LPN did not provide the resident instruction to rinse her mouth following the administration. On 07/08/26 at 8:35 A.M., an interview with LPN confirmed she did not give Resident #10 instruction to rinse her mouth following the administration of the Arnuity inhaler. She further confirmed she had turned her back on the resident and did not see her administer the medication. Review of manufacturer instructions for patient administration of Arnuity dry powder inhaler revealed after inhalation, the resident should rinse their mouth with water. The water should be spit out after rinsing and not swallowed. This is to avoid thrush (a fungal infection of the mouth).		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records, observations and interviews the facility failed to provide comprehensive dementia care to deter resident wandering into other resident rooms. This affected two residents (Resident #8 and #22) of two residents reviewed for abuse. The facility census was 52. Findings include: Review of the medical record for Resident #22 revealed admission to the facility on [DATE] for diagnoses including chronic respiratory failure, lung disease, malnutrition, depression, anxiety, adult failure to thrive, and anemia (low blood count).Review of the minimum data set (MDS) 3.0 quarterly assessment for Resident #22 completed on 06/10/26 revealed a brief interview for mental status (BIMS) score of 13/15 indicating Resident #22 was cognitively intact. Review of section D and E of the MDS for Resident #22 reveal no behavioral disturbances in the last 90 days. Further review of the MDS revealed Resident #22 required supervision to partial assistance with personal care, showering, and dressing. Resident #22 utilized a walker for ambulation. Review of the medical record for Resident #8 revealed admission to facility on 11/12/25 for diagnoses including Alzheimer's Dementia (progress brain disease causing memory impairment and confusion and eventual decline in functional abilities), depression, anxiety, and high blood pressure.Review of the minimum data set (MDS) 3.0 quarterly assessment for Resident #8 completed on 05/22/26 revealed a brief interview for mental status (BIMS) score of 4/15 indicating Resident #8 had severe cognitive impairment. Resident #8 was independent with walking and required no assistive device.Review of the care plan for Resident #8 revealed a care plan specific for risk of wandering and elopement with goal of resident's safety being maintained. The interventions included clearly identifying Resident's #8 room and bathroom, engaging resident in purposeful activity identifying triggers for wandering/elopement, identify wandering /elopement patterns and de-escalation behaviors, and one on one support for protective oversight. Observation on 07/06/26 at 10:15 A.M. of Resident #22's doorway revealed a netted banner with large stop sign in the middle draped across the doorway at approximately chest level, the banner was Velcro and secured to each side of the doorway for easy and quick removal.Interview on 07/06/26 at 2:11 P.M with Resident #22 revealed she recently had an interaction with Resident #8 coming into her room and attempting to get into her bed. She reported she was so upset she almost decked him. Resident #22 further reported that Resident #8 had a history of coming in her room and taking her stuff including her phone and kindle that came up missing and was later found in Resident #8's room. Resident #22 pointed to her door and stated that they put a stop sign banner over the doorway to keep him out and if he tried it again, she is going to deck him next time.Review of a nursing progress note dated 07/03/26 at 7:36 P.M. for Resident #22 revealed a male resident with dementia walked into Resident #22 room resulting in Resident #22 chasing him out of her room and shouting at him and yelling for staff to come and get him. Resident # 22 was very angry.Review of the medical record for Resident #22 revealed an order entered into the electronic medical record on 07/09/26 at 4:37 P.M. authored by the assistant director of nursing (ADON) #700 effective 06/03/26 at 7:37 P.M. to place Velcro stop sign at doorway.Review of Resident #22 thirty-day behavior log revealed no behaviors noted except on 07/03/26 when Resident #22 displayed both physical and verbal behaviors at others.Interviews on 07/09/26 between 8:45 and 8:50 A.M. with certified nursing aide (CNA) #746 and CNA #774 revealed Resident # 8 wandered the hallways a lot and required a lot of redirections.Interview on 07/09/26 at 8:55 A.M with licensed practical nurse (LPN) #762 revealed Resident #8 wandered the halls and was exit seeking frequently. LPN #762 (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	further revealed that Resident #8 tended to exit seek more after returning from an outing with his family. Observation on 07/09/26 at 2:52 P.M. revealed Resident #8 wandering the hallway back and forth near Resident #22's room and looking into her room. Staff were providing verbal cues to Resident #8 to come this way toward the nurses' station when Resident #8 appeared too close to the doorway of Resident #22. Staff would also remind Resident #8 that was not his room and try to redirect him. Resident #8 would state oh, where is my room? It was noted that the Velcro stop sign was in place on the doorway during this time. It was also noted that Resident #8's room was three doors down on same side of hallway but opposite of end of the nurse's station. There was no extra signage on the door of Resident #8 room indicating it was his room other than the name tags used for all residents. Observations on 07/09/26 approximately between 3:45 P.M. revealed LPN #762 and CNA #746 were standing directly outside of Resident #22's room near walls opposite of each other monitoring area to prevent Resident #8 from entering the room. Resident #8 was finally taken back to his room by CNA #746 after several reminders not to go into Resident #22 room. The Velcro stop sign was present on the doorway. Interview on 07/09/26 at 3:45 P.M. with LPN #746 revealed Resident #8 had went into Resident #22 room again despite the stop sign and she became very angry. LPN # 746 reported she did some one on one with Resident #22 to calm her down and are standing near her door trying to prevent an incident again. Interview on 07/09/26 at 4:15 P.M. with LPN #730 revealed Resident #8's and Resident #22's behaviors had been occurring for 1-2 weeks and had to review the medical record to determine exact time that an incident occurred on 07/03/26 when Resident #8 went into Resident #22 room and she got really upset. LPN #730 further reported that Resident #8 does wander a lot and seems to be fixated on Resident #22 but they have not figured out the trigger for the behavior for the fixation of going into Resident #22's room. The LPN stated staff do one on ones with Resident #22 to get her calmed down when he does that. Interview on 07/13/26 at 8:53 A.M. with the licensed social worker (LSW) #750 revealed that in her opinion Resident # 8 should be placed in a locked memory unit which the facility does not provide. LSW #750 revealed that Resident #8 was fixated with Resident #22 and despite the stop sign being placed he still was attempting to go in her room. LSW #750 further indicated she was planning to speak with Resident # 8's wife this week about his disease progress and safety. Interview 07/13/26 at 9:17 A.M. with the Director of Nursing (DON) revealed she was only aware of one time when Resident #8 went into Resident #22 room but he did not do anything, has not had any confrontational behaviors against Resident #22. The DON stated staff put a stop sign up and Resident #22 agreed with that and there have been no further concerns. The DON did verify there was no specific signage on Resident #8's door to remind him where his room was.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, record review, policy review and interview, the facility failed to ensure pharmacy provided medications as ordered and the discrepancy was identified prior to medication administration. This affected one resident (Resident #10) of three reviewed for medication administration. The facility census was 52. Findings include: Review of the medical record for Resident #51 revealed an admission date of 03/28/19. Diagnoses included, but were not limited to bipolar disorder, unspecified kidney failure, and dependence on renal dialysis. Review of medication orders for Resident #51 revealed an order written on 03/03/26 for Lurasidone (antipsychotic medication used to treat bipolar disorder). The order was for Lurasidone give 140 milligrams (mg) by mouth one time a day for bipolar disorder. On 07/08/2026 at 8:35 A.M., observed Lurasidone be prepared by Licensed Practical Nurse (LPN) #715 for Resident #51 to take with her to dialysis to be given at 10:00 A.M. at the dialysis center. There was only one pill in the package. Review of the medication card showed the medication was Lurasidone hydrochloride 120 mg by mouth. The instructions indicated it was to be given with Lurasidone hydrochloride 20 mg for a total of 140 mg by mouth daily. There was no 20 mg dose available in the medication cart. Review of the medical record revealed there was no order for a Lurasidone 20mg dose noted in the medical record. This was confirmed by the DON on 07/08/26 at 2:13 P.M via interview. On 07/08/26 at 2:33 P.M., a telephone interview with Pharmacist #779 from [named pharmacy] revealed when the initial order was written for Lurasidone, it had to be clarified because it did not come in 140 mg. The pharmacist clarified the order with the provider, and then sent the Lurasidone as 120 mg and 20 mg tablets. This occurred for three refills in March, April and May. When the facility requested refills on both 06/25/26 and 07/02/26, the request was sent for 140 mg, however the pharmacy had not sent any 20 mg Lurasidone hydrochloride since 05/21/26. She confirmed this was an error by the pharmacy and Resident #51 should also be getting a 20 mg tablet. On 07/08/26 at 2:50 P.M., an interview with the Director of Nursing confirmed the resident had not had the correct medication since approximately 06/25/26 when the request for a refill was processed incorrectly and the discrepancy was not identified by the administering nurses. Review of a facility policy titled Administering Medication, revised December 2012, revealed medications should be administered in a safe and timely manner, and as prescribed. Medications must be administered in accordance with the orders, including any required time frame. The person administering the medication must check the label three times to verify the right resident, right medication, right dosage, right time and right method of administering the medication. The individual administering the medication would initial the resident's medication administration record before administering the next medication.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and policy review, the facility failed to ensure infection control guidelines were implemented prior to the administration of an injection. This affected one resident (Resident #10) of three observed for medication administration. The facility census was 52. Findings include: Review of the medical record for Resident #10 revealed an admission date of 01/28/26. She was admitted on hospice services. Diagnoses included, but were not limited to, alcoholic cirrhosis of the liver without ascites, chronic obstructive pulmonary disease, type two diabetes mellitus with diabetic chronic kidney disease, chronic respiratory failure, and hepatic encephalopathy. Review of an quarterly Minimum Data Set (MDS) version 3.0, dated 05/14/26, revealed a Brief Interview for Mental Status (BIMS) score of seven on a 0-15 scale which would indicate the resident was moderately cognitively impaired. Review of orders for Resident #10 revealed an order for Insulin Glargine 100 units/milliliter. The resident was to receive 15 units by subcutaneous injection daily. On 07/08/26 at 10:15 A.M., an observation was made of Registered Nurse (RN) #703 administering the insulin glargine 15 units to Resident #10. RN #703 administered the injection without washing her hands and applying gloves prior to administering the medication. On 07/08/26, during an interview immediately following the medication administration, RN #703 reported she realized what she was doing as soon as she started to give the injection, but it was too late. She knew she was supposed to wear gloves before administering medications. On 07/08/26 at 10:29 A.M., Corporate Nurse #900 confirmed the expectation, and the nursing standard was to wear gloves when administering any subcutaneous injection. Review of a facility policy titled Subcutaneous Injections, revised in March 2011, revealed guidelines for the administration of medication by subcutaneous injection. After confirming all orders, the nurse was to perform hand antisepsis, apply gloves, administer the injection, and after giving the injection, remove gloves and wash and dry hands thoroughly. Review of a facility policy under the area of Infection control titled Handwashing/Hand Hygiene, revised in August 2015, revealed the facility considered hand hygiene the primary means to prevent the spread of infection. All personnel would follow the handwashing/hand hygiene procedure to help prevent the spread of infection to personnel, residents and visitors. Alcohol-based hand rub containing at least 62% alcohol or soap and water could be used before preparing or handling medications. Single use disposable gloves should be used before aseptic procedures, when anticipating contact with blood or body fluids, or when in contact with a resident, equipment or environment of a resident who was on contact precautions.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview, the facility failed to ensure nursing staffing information was posted. This had the potential to affect all 51 residents. Findings include: Observations on 07/06/26 at 9:25 A.M. revealed a form posted for providing nursing staff information. The form had the date and census filled in but there was no documentation of scheduled/working hours of Registered Nurses/Licensed Practical Nurses / Certified Nursing Assistants (RN/LPN/CNAs). Dietary Manager #751 was present and verified the form was void of hours scheduled/worked.		