STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365588	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Valley Skilled Nursing and Rehabilitation	25675 East Main Street Coolville, OH 45723

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and policy review the facility failed to ensure food was stored in accordance with professional standards for food service safety. This had the potential to affect 37 residents. The census was 37.Findings include: Observation of the kitchen beginning at 8:34 A.M. on 03/23/26 revealed two packs of nickels hot dog buns expired as of 03/08/26, two packs of hamburger buns expired as of 03/15/26.In the stand up freezer one open improperly sealed, undated, and unlabeled bag of 2 meat patties was observed.One bag containing several portioned pieces of cookie dough were opened, improperly sealed, unsealed, and unlabeled.One bag containing several hot dogs was opened, and unsealed.One bag containing 5 chicken patties was undated.One half- pound package of ground turkey was opened and improperly sealed with the raw turkey outside of the package.In the stand up refrigerator in the kitchen one gallon of whole milk had expired as of 03/21/26, and undated unlabeled bowl of an unknown substance covered with tin foil with MM written on it was present.One container of undated salad, and one container of 3.5 liter of green Jell-o was present and unlabeled, and undated. Interview on 03/23/26 at 8:53 A.M. with Dietary [NAME] #240 confirmed unlabeled, undated, improperly sealed, and expired items within the freezers and refrigerator, and hot dog/ hamburger buns were out of expiration.Review of the undated facility policy titled Food Storage revealed food storage areas shall be clean at all times, all packaged food, canned foods, or food items stored shall be kept clean and dry at all times.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review, the facility failed to ensure multi-use insulin flex pens were stored properly prior to use, insulin flex pens were dated when first used, and inhalers were not left at the bedside unless there was a physician's order to do so. This affected three residents (#3, #4, and #18) of three residents identified by the facility as having the use of insulin that was stored in the [NAME] Unit medication administration cart, and one resident (#5) of five residents observed during medication administration. Findings include: 1. On 03/26/26 at 9:45 A.M., an observation of the medication administration cart for the [NAME] Unit (Rooms 21-37) revealed there were insulin Flex Pens (multi-dose insulin injectable dispensing pen) noted to be stored in the top drawer of the medication administration cart that had not been used yet and/ or without dates written on them when they had been put in use. 1 a.) Resident #3 was noted to have a Semglee (Glargine Insulin) 100 units (u)/ milliliter (ml) Flex Pen that was in the top drawer of the medication administration cart that had been filled on 03/04/26. The Semglee (a long acting insulin used to lower blood sugar levels) Flex Pen had been used, but did not have a date written on it to indicate when the insulin Flex Pen had been removed from the refrigerator and used for the first time. Findings were verified by Registered Nurse (RN) #124. 1 b.) Resident #4 was noted to have a Lantus insulin (a long acting insulin used to lower blood sugar levels) Flex Pen 100 u/ ml stored in the top drawer of the medication administration cart that had been filled on 01/26/26. The Flex Pen had not been used yet, but was not being properly stored in the refrigerator until use. Findings were verified by RN #124. 1 c.) Resident #18 was noted to have a Lantus insulin Flex Pen 100u/ml stored in the top of the medication administration cart that had been filled on 03/11/26. It had not been used and was not being stored in the refrigerator, as it should have been. Findings were verified by RN #124. On 03/26/26 at 9:48 A.M., an interview with RN #124 confirmed insulin Flex pens should be stored in the refrigerator, until they were put in use. They were also to be dated when first used so the nurses knew how long the insulin was good for and when it should be discarded. She stated she believed they were only good for 30 days or so when removed from the refrigerator after their first use. Review of the product information for Lantus insulin for storage, stability, and disposal revealed an unopened vial/ cartridge of LANTUS should be stored in a refrigerator, between 2 degrees C and 8 degrees C. Opened Lantus vials/ cartridges could be kept refrigerated or unrefrigerated (15 to 30 degrees C) for up to 28 days away from direct heat and light, as long as the temperature is not greater than 30 degrees C. Opened LANTUS vials/ cartridges, whether or not refrigerated, must be discarded after 28 days even if they contain insulin. Review of the facility's Storage of Medication policy dated September 2010 revealed insulin products should be stored in the refrigerator until opened. They were to note the date on the label for insulin vials and pens when first used. Opened insulin pens must be stored at room temperature. 2. Record review revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), ischemic cardiomyopathy, depression, (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pulmonary fibrosis, and hypertension. Review of Resident #5's quarterly minimum data set (MDS) completed on 03/02/26 revealed a brief interview for mental status score of 15. The resident required continuous oxygen therapy. Review of Resident #5's care plan completed on 03/17/26 revealed the resident had an alteration in respiratory function and required oxygen, interventions included providing inhalers as ordered. Review of Resident #5's orders revealed an order placed on 10/24/25 for Incruse Ellipta Inhalation Aerosol Powder Breath Activated 62.5 micrograms (mcg) / each actuation (spray) (ACT) (Umeclidinium Bromide). One inhalation inhale orally in the morning for COPD. Review of Resident #5's record revealed no documentation of the resident being permitted to have medications at the bed side, or self-administer medications. Observation on 03/25/26 at 8:35 A.M. revealed an Incruse inhaler on the residents' bedside table within reach. Observation and interview on 02/25/26 at 8:45 A.M. with Registered Nurse (RN) #124 confirmed Resident #5's Incruse Ellipta Inhalation Aerosol Powder Breath Activated 62.5 mcg / ACT (Umeclidinium Bromide) was located on the resident's bedside table.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure a resident and/ or their representative gave informed consent for the use of psychotropic medications. This affected one resident (#44) of five residents reviewed for unnecessary medications. Findings include:Review of Resident #44's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included a malignant neoplasm of an unspecified part of an unspecified lung, malignant neoplasm of the vulva, basal cell carcinoma of the skin, depression, and anxiety disorder. Review of Resident #44's physician's orders revealed the resident had orders to receive Diazepam (an anti-anxiety medication) 5 milligrams (mg) by mouth (po) every 12 hours as needed (prn) for anxiety. The order originated on 03/18/26. She also had an order to receive Venlafaxine HCL (an anti-depressant) 75 mg po every morning for depression. That order was present upon her admission. Review of Resident #44's medication administration record (MAR) for March 2026 revealed the resident was receiving her Venlafaxine HCL 75 mg po daily as ordered. The Diazepam was ordered prn but the resident had not received a dose since the order went into effect on 03/18/26. Further review of Resident #44's medical record revealed it was absent for any documented evidence of the resident and/ or her representative having provided the facility with an informed consent, after the facility had educated them on the risks and benefits associated with those psychotropic medications. Findings were verified by the facility's Director of Nursing (DON). On 03/24/26 at 11:55 A.M., an interview with the facility's DON confirmed they did not have evidence of Resident #44 or her resident representative having been given education on the risks/ benefits of taking Venlafaxine or Diazepam to be able to give an informed consent for the use of those psychotropic medications. She provided an Informed Consent For Use of Psychotropic Medications pertaining to the Venlafaxine and Diazepam, that had been provided to the resident that day (03/24/26), which covered the necessary information for the resident to be able to give an informed consent. She stated she did not know what happened to the prior consents and they should have been completed upon the resident's admission. They had several admissions occurring around that time, when Resident #44 was admitted , and was not sure what happened with it. The facility's Regional Nurse Consultant #300 denied the facility had a policy specific to the use of Psychotropic medications when requested.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents received copies of their quarterly statements from their resident fund accounts. This affected one resident (#37) of five residents reviewed for resident fund accounts. The facility census was 37. Findings include:Record review revealed Resident #37 was admitted to the facility on [DATE] with diagnoses including multiple sclerosis and chronic obstructive pulmonary disease. Review of a minimum data set (MDS) dated [DATE] revealed Resident #37's cognition remained intact and she had no behaviors. Review of Resident Council minutes dated 02/10/26 revealed there was a concern residents were not receiving statements from their personal account. Interview on 03/23/26 at 1:29 P.M. with Resident #37 revealed she does not receive a copy of her personal statements, but information was reviewed verbally. Resident #37 stated she would prefer a paper copy of her statement. Review of Resident #37's resident fund account revealed no evidence of a signed quarterly statement for the first three quarters of 2025. Interview on 03/26/26 at 10:17 A.M. with Business Office Manager (BOM) #500 confirmed there was no evidence of signed quarterly statements for Resident #37 for the first three quarters of 2025.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and interview, the facility failed to ensure a resident's physician was notified the resident's equipment used for treatment of lymphedema was broken for over a month impacting the treatment the resident was to receive. This affected one resident (#37) of one resident reviewed for lymphedema pumps. The facility census was 37. Findings include:Record review revealed Resident #37 was admitted to the facility on [DATE] with diagnoses including multiple sclerosis and chronic obstructive pulmonary disease.Review of a minimum data set assessment dated [DATE] revealed Resident #27's cognition remained intact, she had no behaviors, was dependent on staff for toileting hygiene, and was occasionally incontinent of bowel and bladder.Review of a care plan dated 09/03/25 revealed Resident #37 had edema to lower extremities related to lymphedema. The goal was to maintain current level of socialization and maintain current physical level abilities. Interventions included bilateral lower extremity wraps as ordered and as tolerated; staff to monitor and notify physician of any decline; and use lymphedema pumps as ordered and as tolerated.Review of orders revealed Resident #37 had an order in place dated 04/14/25 for lymphedema pumps on for 60 minutes every morning and at bedtime for lymphedema to bilateral lower extremities with the pressure set at 40. Additionally, Resident #37 had an order dated 04/14/25 for lymphedema pumps to come off after 60 minutes every morning and at bedtime for lymphedema to bilateral lower extremities.Review of an electronic medication administration record (eMAR) note dated 10/20/25 at 2:43 P.M. revealed Resident #37 stated her lymphedema pumps were broken and she was awaiting UPS to pick them up. The physician was made aware.Review of an eMAR note dated 10/26/25 revealed Resident #37 stated her lymphedema pumps were broken and she was awaiting UPS to pick them up.Review of an eMAR note dated 10/30/25 at 12:35 P.M. revealed Resident #37 stated her lymphedema pumps were broken and she was awaiting UPS to pick them up.Review of an eMAR note dated 11/03/25 at 1:33 P.M. revealed Resident #37 stated her lymphedema pumps were broken and she was awaiting UPS to pick them up.Review of an eMAR note dated 11/04/25 at 6:47 P.M. by Licensed Practical Nurse (LPN) #136 revealed Resident #37's lymphedema pumps were broken.Review of an eMAR note dated 11/07/25 at 9:44 A.M. by LPN #136 revealed Resident #37's lymphedema pumps were broken.Review of an eMAR note dated 11/08/25 at 12:39 P.M. revealed Resident #37's lymphedema pumps were broken.Review of an eMAR note dated 11/09/25 at 12:06 P.M. by LPN #136 revealed Resident #37's lymphedema pumps were broken.Review of an eMAR note dated 11/10/25 at 9:37 A.M. by LPN #136 revealed Resident #37's lymphedema pumps were broken.Review of an eMAR note dated 11/11/25 at 12:35 P.M. by LPN #220 revealed Resident #37's lymphedema pumps were broken.Review of an eMAR note dated 11/12/25 at 12:33 P.M. revealed Resident #37's lymphedema pumps were broken.Review of an eMAR note dated 11/17/25 at 10:29 A.M. by Registered Nurse (RN) #302 revealed Resident #37's lymphedema pumps were broken.Review of an eMAR note dated 11/18/25 at 1:51 P.M. by RN #302 revealed Resident #37's lymphedema pumps were broken.Review of an eMAR note dated 11/21/25 at 10:55 A.M. revealed Resident #37's lymphedema pumps were broken.Review of an eMAR note dated 11/22/25 at 9:37 A.M. revealed Resident #37's lymphedema pumps were broken.Review of an eMAR note dated 11/23/25 at 10:43 A.M. revealed Resident #37's lymphedema pumps were broken.Review of an eMAR note dated 11/26/25 at 11:12 A.M. revealed Resident #37's lymphedema pumps were broken.Review of an eMAR note dated 11/27/25 at 10:30 A.M. revealed Resident #37's lymphedema pumps were broken.Review of an eMAR note dated 12/01/25 at 9 A.M. revealed revealed Resident #37's lymphedema pumps were broken.Review of an eMAR note dated 12/02/25 at 9:07 A.M. revealed Resident #37's lymphedema pumps were broken.Review of an eMAR note dated 12/30/25 at 11:37 P.M. revealed Resident #37's lymphedema pumps were taken off, no behaviors noted at this time, and staff would continue to (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monitor.Interview on 03/26/26 at 7:33 A.M. with Director of Nursing (DON) revealed she had found out the lymphedema pumps were broken by reviewing the shift reports, she spoke with Resident #37 who told her the company the pumps came from. The DON stated at some point someone from the company came in to fix the pumps and they were working again, then it stopped airing up like it was supposed to and had to be sent out to the company. The DON confirmed she was not sure the exact time the pumps quit working because no one informed her but she did educate the resident to ensure she was notified in the future. The DON confirmed if the pumps were broken twice, it was only documented once (10/20/25) in the medical record the physician was notified and there was no evidence to support whether the physician knew the lymphedema pumps were broken for more than a month.Review of an undated policy titled Status Change in Resident Condition - Notification revealed the facility will promptly notify the resident, his/her attending physician and the responsible party of changes in the resident's condition and/or status.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on review of a Beneficiary Notice list, review of a Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review form, review of liability notices, and staff interview, the facility failed to ensure a resident received the appropriate liability notices, when their Medicare (MCR) Part A services ended, and they remained in the facility. This affected one resident (#11) of three residents reviewed for beneficiary notices. Findings include: Review of a Beneficiary Notice list of all residents, who were discharged from a MCR covered Part A stay, with benefit days still remaining in the past six months revealed Resident #11 was identified as having a discharge date from MCR Part A services on 10/21/25. She was also indicated on that list to have remained in the facility following her discharge from MCR Part A services. Review of a Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review form completed by the facility revealed Resident #11 began receiving MCR Part A skilled services on 09/11/25. Her last covered day of MCR Part A services was on 10/21/25. The provider (facility) indicated the facility initiated the resident's discharge from MCR Part A services, when the resident's benefit days had not been exhausted. They indicated on that form that the resident was given a Notice of MCR Non-Coverage (NOMNC), CMS Form 10123, but did not provide the resident with a SNF Advanced Beneficiary Notice (ABN), CMS Form 10055, despite the resident remaining in the facility after being cut from MCR Part A services. The facility was supposed to explain on the form why the resident was not given that notice, but no explanation was provided. On 03/26/26 at 8:55 A.M., an interview with Social Service Designee #132 revealed she was not sure why Resident #11 was not provided a CMS Form 10055, when her MCR Part A services ended on 10/21/25 and she remained in the facility. She stated she would have to check with the business office manager to see why the resident was not given that notice. On 03/26/26 at 9:05 A.M., an interview with the facility's Administrator revealed Resident #11 did not receive a SNF ABN (CMS Form 10055) because she remained in the facility and did not wish to continue Part B therapy services. That was the directive they received from their corporate office and had been following what they had been told. She acknowledged residents that had been cut from MCR Part A services should receive the SNF ABN (CMS Form 10055) to notify them of the right to appeal the facility's decision to discharge them from MCR Part A services. The resident should be afforded the right to continue to receive those skilled services pending the appeal with the responsibility of paying for those skilled services in the event their appeal was denied. The resident was to mark on that form if they wanted to continue to receive those skilled services that were ending or if they wanted to opt out of the appeal process. Regional Nurse Consultant #300 revealed the facility did not have a policy specific to liability notices. She stated they just followed the regulations pertaining to liability notices.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview the facility failed to provide a safe, clean, comfortable environment for residents. This affected two residents (#20, #4). The census was 37.Findings include:1.Interview on 03/23/26 at 10:22 A.M. with Resident #20's Representative #800 revealed there were some environmental concerns with the resident's room. The door does not close all the way, you have to slam it to shut it. The light above the resident's bed does not work, there is no string to pull it, so they have to turn the light on above the other bed. The walls look bad, there are scuff marks everywhere on doors, walls, damage to the dry wall, paint peeled off. The drawers don't close all the way, and there are drawers without fronts on them, so they're not useable.Observation on 03/23/26 at 10:25 A.M. revealed Resident #20's room had several scuff marks on the bathroom door and along the walls. Above the resident's head of bed on the wall revealed torn paint and dry wall, and scuff marks. The overhead light above the resident bed did not have a draw string and was unable to be turned on. Upon closing the resident's door it was unable to be shut without aggressive force resulting in a loud disruptive sound.2. Interview on 03/23/26 at 12:47 P.M. with Resident #4 revealed the scuffs and torn wall behind the head of bed need repaired. Resident #4 stated they have been waiting a long time for them to get repaired. Resident #4 stated her drawers do not have fronts on them so she can not use them.Observation on 03/23/26 at 12:48 P.M. revealed scuffed and torn wall above the head of Resident #4's bed. Observation of the residents' drawers revealed the 2nd drawer on the left hand side does not have a front and is unable to be used.Interview and observation with the facility Administrator on 03/25/26 at 9:49 A.M. confirmed environmental issues across several resident rooms including peeled paint, torn dry wall, scuff marks along walls and doors, doors unable to be properly closed, and overhead lights unable to be turned on due to not having a draw string.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and interview the facility failed to ensure residents or their representative received a bed hold notice upon transfer. This affected one resident (#20) of three residents reviewed for hospitalization. The census was 37.Findings include:Record review revealed Resident #20 was admitted to the facility on [DATE] with diagnoses including cerebral infarction, dysphagia, chronic kidney disease stage 3, anemia, and supraventricular tachycardia. Interview on 03/23/26 at 10:19 A.M. with Resident #20's power of attorney revealed the resident was sent to the hospital on [DATE] due to pulling out her feeding tube (Jejunostomy tube (J-tube). Resident #20's power of attorney revealed they did not receive a bed hold notice upon transfer/ discharge. Review of Resident #20's progress notes revealed a note dated 03/19/26 at 11:53 P.M. that Resident #20 was being sent to the Emergency Department due to pulling out her J-tube. Review of Resident #20's progress notes revealed a note dated 03/23/26 at 3:49 P.M. that Resident #20 was being sent to the Emergency Department due to her J-tube being dislodged. Review of Resident #20's record revealed no documentation a bed hold notice was completed for Resident #20 during her hospital stays. Interview on 03/25/26 at 2:30 P.M. the facility Administrator confirmed Resident #20's representatives was not given a bed hold notice upon the resident's transfer to the hospital. Review of the undated facility policy titled Bed Hold Policy revealed Pursuant to Ohio law, the facility will offer Medicaid residents the opportunity to hold the bed for a maximum of 30 days per calendar year. After admission to the nursing home, and before a resident is transferred or leaves the facility the facility will provide the resident and/or their sponsor with the following Information in writing, the bed hold policy of the state and facility policy.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to develop and implement a comprehensive person-centered care plan for a resident with post traumatic stress disorder (PTSD). This affected one resident (#2) of three residents reviewed for development and implementation of the comprehensive care plan. The census was 37. Findings include:Record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including diabetes, asthma, aphasia, multiple sclerosis, von Willebrand disease, insomnia, urinary retention, anxiety, post traumatic stress disorder, and major depressive disorder.Review of Resident #2's quarterly Minimum Data Set (MDS) assessment completed on 02/09/26 revealed diagnoses of peripheral vascular disease, urinary tract infections, hyperlipidemia, aphasia, multiple sclerosis, anxiety, depression, and post-traumatic stress disorder. Review of the resident's record revealed no documentation of a care plan related to post traumatic stress disorder including goals and interventions to meet the resident's mental and psychosocial needs.Interview on 03/25/26 at 3:45 P.M. with the Assistant Director of Nursing confirmed Resident #2 does not have a care plan in place related to post traumatic stress disorder including goals and interventions to meet the resident's mental and psychosocial needs, specific to her trauma and trigger.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure care conferences were scheduled in conjunction with the minimum data set (MDS) assessments quarterly. This affected one resident (#1) of two residents reviewed for care conferences. The facility census was 37. Findings include:Record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia, type II diabetes, and chronic obstructive pulmonary disease. Review of a minimum data set (MDS) assessment dated [DATE] revealed Resident #1's cognition remained intact and he had behaviors including hallucinations, delusions, and refusing care one to three days during the review period. Review of the MDS listing revealed Resident #1 had assessments completed 07/12/25, 10/12/25, 01/12/26, and one scheduled for 04/12/26. Review of care conferences revealed Resident #1 had care conferences on 07/16/25, 10/10/25, and 02/13/26. Interview on 03/24/26 at 11:19 A.M. with Social Worker (SW) #132 revealed care conferences are completed quarterly, within 72 hours of admission, and for significant changes. SW #132 stated she followed the MDS schedule to ensure care conferences were completed quarterly. Follow up interview on 03/25/26 at 8:44 A.M. with SW #132 confirmed Resident #1's care conferences were not completed quarterly in conjunction with the MDS assessments. Review of an undated facility policy titled Care Conference revealed the MDS nurse is responsible for coordinating the routine schedule of resident's care conference and the MDS assessment, care areas and triggers as well as interventions for each area would be discussed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interview, and policy review, the facility failed to ensure residents requiring assistance with Activities of Daily Living (ADLs) received nail care and showers as scheduled. This affected two residents (#33 and #44) of four residents reviewed for ADL assistance. The facility census was 37. Findings include:1.Record review revealed Resident #33 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, type II diabetes, and dementia. Review of a care plan dated 07/03/25 revealed Resident #33 required assistance with ADLs related to cognitive impairment, dementia, and weakness. The goals were to continue to participate in ADLs as able and have no decline in ADLs through the review, and remain clean, dry, odor free and appropriately dressed through the review date. Interventions included but were not limited to requiring non-weight bearing assistance (including steadying, contact guard assistance or guided maneuvering) with shower, and staff will assist as needed with daily hygiene and will assist with showering residents as per facility policy weekly. Review of a minimum data set (MDS) assessment dated [DATE] revealed Resident #33 had severely impaired cognition, had physical and verbal behaviors one to three days, refused care four to six days, and assistance needed for showering/bathing was marked not applicable. Review of a shower schedule revealed Resident #33 received showers on Mondays and Thursdays on nightshift. Review of showers revealed Resident #33 did not receive a shower as scheduled on 01/01/26, 01/05/26, and 02/12/26. Observation on 03/23/26 at 2:37 P.M. revealed Resident #33 was seated in her wheelchair in the dining room and her hair appeared to be slightly greasy. Interview on 03/25/26 at 9:55 A.M. with Licensed Practical Nurse (LPN) #137 revealed she thought Resident #33's hair was damp due to wetting her hair when she was getting out of bed. LPN #137 touched Resident #33's hair and confirmed it was a little bit greasy. Interview on 03/25/26 at 10:00 A.M. with the Director of Nursing (DON) confirmed Resident #33 missed showers on 01/01/26, 01/05/26, and 02/12/26. Review of an undated policy titled Personal Care/Bathing revealed residents will receive personal care in the facility according to the resident's plan of care to promote dignity, cleanliness, and general well-being. Resident are interviewed during the admission process, quarterly and as needed regarding the frequency they want for bathing. Nail care, oral care, and shaving are also offering during routine personal care and bathing, and as needed. If the resident in unable to relay this information, attempts are made to obtain information from the responsible party. 2. Review of Resident #44's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included a malignant neoplasm of an unspecified part of an unspecified lung, malignant neoplasm of vulva, basal cell carcinoma of the skin, chronic obstructive pulmonary disease, adult onset diabetes mellitus, difficulty walking, osteoarthritis, depression, and anxiety disorder. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #44's Minimum Data Set (MDS) assessments revealed her admission MDS was still in process. Her initial care plans included an activities of daily living (ADL) care plan that indicated the resident required assistance with ADL's related to weakness. The goal was for the resident to remain clean, dry, odor free, and appropriately dressed through the review date. She was also to continue to participate in ADL's as able and have no decline in ADL's through the review date. The interventions included the need for the staff to adjust care as needed to meet the resident's needs, staff were to encourage the resident to participate in ADL's during care, and staff would assist as needed with daily hygiene. Review of Resident #44's shower/ bathing documentation revealed the resident was documented as having been provided a bed bath five times since her admission to the facility. Her last documented bed bath was on 03/23/26. It did not specify what, if any, other personal hygiene care was provided as part of those bed baths. On 03/23/26 at 10:30 A.M. an observation of Resident #44 noted her to be lying in bed in a supine position with the head of the bed raised. She had her eyes closed and her fingernails were noted to be long and in need of a trimming. On 03/24/26 at 10:35 A.M., a follow up observation of Resident #44 noted the resident to be sitting up in her wheelchair in her room. Her fingernails remained long and in need of being trimmed. An interview with the resident, at the time of the observation, revealed it was her preference to have her fingernails kept trimmed. She did not like to have them grown out and denied anyone had helped her trim them, since she was admitted to the facility on [DATE]. On 03/24/26 at 11:02 A.M., an interview with Certified Nursing Assistant (CNA) #266 revealed the aides were responsible for performing nail care on the residents, even if the resident was a diabetic. She stated a podiatrist would have to do their toenails, but the aides could trim their fingernails. She reported Resident #44 needed assistance with personal hygiene to include nail care. She was not sure what days the resident was scheduled to receive her shower/ bath. She had worked the past two days and denied the resident had been on their list to get a shower/ bath the past two days. She checked her shower schedule they had in a binder at the nurses' station and was not able to find the resident's name on the current shower schedule. She was informed the resident reported she would like assistance with trimming her fingernails. She thanked the surveyor for bringing that to her attention and said she would get some nail clippers and go trim them right then. She confirmed Resident #44's fingernails were long and it was obvious they had not been trimmed in the week the resident had been there. Review of the facility's policy on Personal Care/ Bathing (not dated) revealed the purpose of the policy was to receive personal care in the facility according to the resident's plan of care to promote dignity, cleanliness, and general well-being. Nail care was to be offered during routine personal care and bathing, and as needed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure the bowel protocol was followed when residents did not have bowel movements for three days or longer. This affected two residents (#37, #44) of five residents reviewed for unnecessary medications. Additionally, the facility failed to ensure a resident received physician ordered treatment for lymphedema. This affected one resident (#37) of one resident reviewed for lymphedema pumps. The facility census was 37. Findings include:1a.Record review revealed Resident #37 admitted to the facility on [DATE] with diagnoses including multiple sclerosis and chronic obstructive pulmonary disease. Review of a minimum data set assessment dated [DATE] revealed Resident #27's cognition remained intact, she had no behaviors, was dependent on staff for toileting hygiene, and was occasionally incontinent of bowel and bladder. Review of the bowel record revealed Resident #37 did not have a bowel movement from 03/01/26 through 03/06/26 or 03/08/26 through 03/11/26. Review of orders revealed Resident #37 had an order dated 03/12/26 for senna 8.6 milligrams (mg) one tablet by mouth every afternoon. Review of orders revealed Resident #37 had an order dated 03/20/26 for miralax powder 17 grams per scoop give one scoop in the afternoon for constipation. Interview on 03/26/26 at 11:08 A.M. with Administrator confirmed Resident #37 did not have a bowel movement from 03/01/26 through 03/06/26 and from 03/08/26 through 03/11/26 and did not have any intervention after three days of constipation. Administrator also confirmed the bowel management protocol for the facility was not followed. Review of an undated policy titled Bowel Management and Treatment revealed resident who have not had a bowel movement for three consecutive days will have the following protocol initiated, unless the resident has individual orders specific to bowel management, or where the orders below would be contraindicated for the resident: -Initial nurse receiving shift alert and identifying the lack of bowel movement for three days will begin the following bowel protocol for the residents on the list: assess bowel sounds; administer 30 milliliters (ml) of milk of magnesia; if the resident refuses the milk of magnesia the nurse will notify the attending physician and document such on the medication administration record (MAR) and in the nurses' notes; document on the MAR and in the nurses' notes when the resident has a bowel movement and then the resident will be placed on the modified promotional bowel regimen. -The medication nurse on the next shift will check the list upon the beginning of their shift and the following with be performed: assess for bowel sounds; if the resident does not have a bowel movement on the prior shift after receiving the milk of magnesia, the licensed nurse will administer a suppository (type and amount to be determined by the physician or medical director); if the resident refuses the suppository, the nurse will notify the attending physician and document on the MAR and nurses' notes; document on the MAR and in the nurses' notes when the resident has a bowel movement and then the resident will be placed on the promotional bowel regimen. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The medication nurse for the third consecutive shift/next shift will check the list at the start of their shift and the following will be performed: assess bowel sounds' if the resident did not have a bowel movement on the previous shift after receiving the suppository, the nurse will administer an enema per the physician's order; if the resident refuses the enema, the nurse will notify the physician and document on the MAR and nurses' noted; document on the MAR and nurses' notes when the resident has a bowel movement and then place the resident on the promotional bowel regimen; if the resident does not have a bowel movement within one hour of receiving the enema, notify the attending physician for further instruction and document such in the MAR and nurses' notes. The promotional bowel protocol includes the following: review medications the resident is currently receiving; obtain physician orders to hold all laxative and enema orders including stool softeners and bulk laxatives; daily administration of natural laxative or prune/fiber mixture with medication pass; increase fluid intake for the resident; and offer half a cup of yogurt to the resident daily. Assess bowel sounds each shift and document and each shift the nurse documents on the MAR/treatment administration record (TAR) when the resident has had a bowel movement. 1b. Record review revealed Resident #37 admitted to the facility on [DATE] with diagnoses including multiple sclerosis and chronic obstructive pulmonary disease. Review of a minimum data set assessment dated [DATE] revealed Resident #37's cognition remained intact, she had no behaviors, was dependent on staff for toileting hygiene, and was occasionally incontinent of bowel and bladder. Review of a care plan dated 09/03/25 revealed Resident #37 had edema to lower extremities related to lymphedema. The goal was to maintain current level of socialization and maintain current physical level abilities. Interventions included bilateral lower extremity wraps as ordered and as tolerated; staff to monitor and notify physician of any decline; and use lymphedema pumps as ordered and as tolerated. Review of orders revealed Resident #37 had an order in place dated 04/14/25 for lymphedema pumps on for 60 minutes every morning and at bedtime for lymphedema to bilateral lower extremities with the pressure set at 40. Additionally, Resident #37 had an order dated 04/14/25 for lymphedema pumps to come off after 60 minutes every morning and at bedtime for lymphedema to bilateral lower extremities. Review of an electronic medication administration record (eMAR) note dated 10/20/25 at 2:43 P.M. revealed Resident #37 stated her lymphedema pumps were broken and she was awaiting UPS to pick them up. The physician was made aware. Review of an eMAR note dated 10/26/25 revealed Resident #37 stated her lymphedema pumps were broken and she was awaiting UPS to pick them up. Review of an eMAR note dated 10/30/25 at 12:35 P.M. revealed Resident #37 stated her lymphedema pumps were broken and she was awaiting UPS to pick them up. Review of an eMAR note dated 11/03/25 at 1:33 P.M. revealed Resident #37 stated her lymphedema pumps were broken and she was awaiting UPS to pick them up. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an eMAR note dated 11/04/25 at 6:47 P.M. by Licensed Practical Nurse (LPN) #136 revealed Resident #37's lymphedema pumps were broken. Review of an eMAR note dated 11/07/25 at 9:44 A.M. by LPN #136 revealed Resident #37's lymphedema pumps were broken. Review of an eMAR note dated 11/08/25 at 12:39 P.M. revealed Resident #37's lymphedema pumps were broken. Review of an eMAR note dated 11/09/25 at 12:06 P.M. by LPN #136 revealed Resident #37's lymphedema pumps were broken. Review of an eMAR note dated 11/10/25 at 9:37 A.M. LPN #136 revealed Resident #37's lymphedema pumps were broken. Review of an eMAR note dated 11/11/25 at 12:35 P.M. by LPN #220 revealed Resident #37's lymphedema pumps were broken. Review of an eMAR note dated 11/12/25 at 12:33 P.M. revealed Resident #37's lymphedema pumps were broken. Review of an eMAR note dated 11/17/25 at 10:29 A.M. by Registered Nurse (RN) #302 revealed Resident #37's lymphedema pumps were broken. Review of an eMAR note dated 11/18/25 at 1:51 P.M. by RN #302 revealed Resident #37's lymphedema pumps were broken. Review of an eMAR note dated 11/21/25 at 10:55 A.M. revealed Resident #37's lymphedema pumps were broken. Review of an eMAR note dated 11/22/25 at 9:37 A.M. revealed Resident #37's lymphedema pumps were broken. Review of an eMAR note dated 11/23/25 at 10:43 A.M. revealed Resident #37's lymphedema pumps were broken. Review of an eMAR note dated 11/26/25 at 11:12 A.M. revealed Resident #37's lymphedema pumps were broken. Review of an eMAR note dated 11/27/25 at 10:30 A.M. revealed Resident #37's lymphedema pumps were broken. Review of an eMAR note dated 12/01/25 at 9 A.M. revealed revealed Resident #37's lymphedema pumps were broken. Review of an eMAR note dated 12/02/25 at 9:07 A.M. revealed Resident #37's lymphedema pumps were broken. Review of an eMAR note dated 12/30/25 at 11:37 P.M. revealed Resident #37's lymphedema pumps (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were taken off, no behaviors noted at this time, and staff would continue to monitor. Interview on 03/26/26 at 7:33 A.M. with the Director of Nursing (DON) revealed she had found out the lymphedema pumps were broken by reviewing the shift reports, she spoke with Resident #37 who stated the company the pumps came from. The DON stated at some point someone from the company came in to fix the pumps and it was working again, then it stopped airing up like it was supposed to and had to be sent out to the company. The DON confirmed she was not sure the exact time the pumps quit working because no one informed her but she did educate the resident to ensure she was notified in the future. Interview on 03/26/26 at 8:04 A.M. with the Administrator revealed the documentation is unclear as to when the pumps were broken and fixed. 2. Review of Resident #44's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included a malignant neoplasm of an unspecified part of an unspecified bronchus/ lung, malignant neoplasm of vulva, osteoarthritis, polyneuropathy, age related physical debility, and difficulty walking. Review of Resident #44's physician's orders revealed the resident had an order to receive Miralax (a bulk forming laxative) 17 grams by mouth (po) every morning for constipation. She also had an order to receive Sennosides (a stimulant laxative) 8.6 milligrams po twice a day for constipation. There were no laxatives ordered for the resident to be used on an as needed (prn) basis. Review of Resident #44's bowel movement record documented under the task tab of the electronic medical record (EMR) from 03/17/26 thru 03/24/26 revealed the resident's last recorded bowel movement occurred on 03/18/26. No bowel movements had been documented as having occurred between 03/19/26 thru 03/24/26 (six days). Review of Resident #44's medication administration record (MAR) for March 2026 revealed the resident had been given her Miralax and Sennosides on a scheduled basis as ordered. There was no documented evidence of the resident having been given any additional medications to help promote a bowel movement on or around 03/21/26 (three days since her last bowel movement). Review of Resident #44's progress notes revealed there was no documented evidence of the facility's nurses reaching out to the physician to notify him of the resident's lack of a bowel movement greater than three days. There was also no evidence of any new orders being received to help promote the resident to have a bowel movement through use of any other laxatives to include Milk of Magnesia (MOM), suppositories, or enemas. On 03/24/26 at 11:05 A.M., an interview with the facility's Director of Nursing (DON) and Regional Nurse Consultant #300 revealed the facility did not document bowel movements anywhere else, other than under the task tab of the EMR. They acknowledged Resident #44 was not documented as having had a bowel movement for six days without evidence of any interventions to help promote her to have a bowel movement. Review of the facility's policy on Bowel Management and Treatment (not dated) revealed the purpose of the policy was to achieve control of bowel evacuation on a routine basis which may be indicated by an independent or assisted stool every two to three days. Its purpose was also to avoid constipation. For residents that have not had a bowel movement for three consecutive days, they would have the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following protocol initiated: 1. The initial nurse receiving the alert and identifying the lack of BM for three days, would assess the resident's bowel sounds, administer 30 milliliters (ml) of MOM; if the resident refuses the MOM, the nurse would notify the attending physician and document such on the MAR and in the progress notes; document on the MAR and in the nurses notes when the resident had a bowel movement. 2. The medication nurse on the next shift would check the list upon beginning of her shift and would again assess for bowel sounds; if the resident did not have a bowel movement on the prior shift, after receiving the MOM, the licensed nurse would administer a suppository per physician's orders; if the resident refused the suppository, the nurse would notify the attending physician and document such on the MAR's and in the progress notes; they were to document on the MAR and in the nurses' notes when the resident had a bowel movement. 3. The medication nurse for the third consecutive shift/ next shift would check the list at the start of her shift and would assess bowel sounds; if the resident did not have a bowel movement on the prior shift, after receiving the suppository, the nurse would administer an enema per physician's order; if the resident refused the enema, the nurse would notify the attending physician and document such on the MAR and in the nurses' notes; document on the MAR and in the nurses notes when the resident had a bowel movement; if the resident did not have a bowel movement within one hour of receiving the enema, notify the attending physician for further instruction and document such in the MAR and in the nurses' notes.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to ensure interventions to prevent pressure injuries were in place. This affected one resident (#6) of two residents reviewed for pressure injuries. The facility census was 37. Findings include: Record review revealed Resident #6 was admitted to the facility on [DATE] with diagnoses including dementia and hypertension. Review of an order dated 09/17/25 revealed Resident #6 had a pressure reducing mattress to bed. Review of a care plan dated 09/23/25 revealed Resident #6 was at risk for impaired skin integrity/pressure ulcers related to concussion and decreased mobility. Goals included skin to be free of breakdown and open areas will be healed without complications. Interventions included but were not limited to air mattress to bed at all times, elevate heels off mattress, inspect skin during routine daily care, liquid protein daily for wound healing, lotion to skin as needed, medications as ordered, pad and protect skin as needed, peri-care after each episode of incontinence, pillows for positioning, pressure reduction cushion to chair as tolerated, pressure reduction devices as ordered, and skin assessment as ordered. Review of a minimum data set (MDS) assessment dated [DATE] revealed Resident #6's cognition was severely impaired, she had no behaviors, was dependent on staff for bed mobility, had no pressure areas, and had pressure reducing devices in place for wheelchair and bed. Review of a Braden Scale for Predicting Pressure Sore Risk assessment was completed on 01/14/26 and revealed resident scored a nine indicating very high risk. Review of a weight from 03/01/26 at 10:31 A.M. revealed Resident #6 weighed 101.1 pounds. Review of an order dated 03/04/26 revealed Resident #6 would have wound to coccyx cleansed with soap and water, triad paste applied and leave open to air. Review of a skin check assessment dated [DATE] revealed Resident #6 had pressure area/reddened area to coccyx. Observation on 03/23/26 at 9:45 A.M. revealed Resident #6's alternating air mattress was set to the weight of 270 pounds. Observation and Interview on 03/23/26 at 3:42 P.M. with Registered Nurse (RN) #145 confirmed Resident #6's alternating air mattress was set to 270 pounds. Review of an undated policy titled Pressure Ulcer Prevention Intervention revealed the resident's skin will be assessed and monitored on a routine basis as is outline in the skin assessment protocols. Preventative measure will be implemented in accordance with the residents' assessed risk level and for developed of skin integrity impairment and risk factors that may enhance the residents' ability to develop skin integrity impairment.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide indwelling urinary catheter care. This affected one resident (#20) of six residents reviewed with indwelling urinary catheters. The census was 37.Findings include:Medical record review revealed Resident #20 was admitted to the facility on [DATE] with diagnoses including cerebral infarction, dysphagia, chronic kidney disease stage 3, anemia, and supraventricular tachycardia.Review of Resident #20's admission minimum data set (MDS) assessment completed on 03/12/26 revealed the resident had an indwelling urinary catheter.Review of Resident #20's care plan dated 03/10/26 revealed the resident is at risk for infection or worsening infection due to indwelling medical devices, urinary catheter, and J-tube for nutrition.Review of Resident #20's care plan revealed completed on 03/10/26 revealed the resident has an alteration in elimination related to indwelling urinary catheter. Interventions include Foley catheter care every shift and as needed (PRN).Review of Resident #20's record revealed no evidence of indwelling urinary catheter care being completed for the resident.Interview on 03/26/26 at 12:44 PM with the facility Director of Nursing (DON) confirmed there was no documentation of indwelling catheter care being completed for Resident #20. Review of the undated facility policy titled Foley Catheter Care revealed the nursing staff will provide indwelling urinary catheter care in the morning, before the hour of sleep, and as needed per physician order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365588	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Valley Skilled Nursing and Rehabilitation	25675 East Main Street Coolville, OH 45723

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents received dental services. This affected one resident (#14) of three residents reviewed for dental services. The facility census was 37. Findings include:Record review revealed Resident #14 was admitted to the facility on [DATE] with diagnoses including dementia and anemia. Review of an order dated 08/27/24 revealed Resident #14 may see audiology, vision, dental, and podiatry. Review of a care plan revised on 03/26/25 revealed Resident #14 was at risk for oral/dental health problems related to natural teeth. The goal was to remain free from oral/dental complications through the next review date. Interventions included coordinate arrangements for dental care and transportation as needed/ordered (07/24/24); require oral inspections with oral care and report changes to a nurse (07/24/24); monitor/document/report to physician as needed signs and symptoms or oral problems needing attention: pain, abscess, debris in mouth, lips cracked or bleeding, teeth missing, loose, or broken, eroded, decayed teeth, tongue (black coated, inflamed, white, smooth), ulcers, lesions (07/24/24); and provide mouth care (07/24/24). Review of a minimum data set (MDS) assessment dated [DATE] revealed Resident #14's cognition was severely impaired, she refused care four to six days, required set-up help for oral hygiene, and had no obvious or likely cavity or broken natural teeth. Review of a quarterly nursing assessment dated [DATE] revealed Resident #14 had no dental concerns. Review of an oral assessment dated [DATE] revealed Resident #14 had decayed or broken teeth. Interview on 03/23/26 at 11:03 A.M. with Resident #14's representative revealed the resident had admitted to the facility with a chipped tooth but she was not sure if the facility had arranged dental services for her. Interview on 03/24/26 at 2:41 P.M. with the Administrator revealed Resident #14 had not seen a dentist since 10/2024, the facility changed dental providers, and she was not re-enrolled with the new provider. Interview on 03/24/26 at 4:38 P.M. with the Director of Nursing (DON) revealed she completed an oral assessment and Resident #14 had three broken teeth and one chipped tooth. The DON confirmed an MDS was completed in 01/23/26 but no corresponding oral assessment was completed. Review of a note dated 03/24/26 at 4:52 P.M. by Social Worker (SW) #137 revealed she spoke with Resident #14's representative via phone and received consent for resident to be seen by the dentist and audiologist. Review of a nursing note dated 03/24/26 at 4:52 P.M. by the Director of Nursing (DON) revealed a dental evaluation was completed and referral to dentist was initiated. All were aware. Review of an undated policy titled Oral Health Care and Assessment revealed an oral assessment should be completed upon admission, quarterly, and significant change. The licensed nurse will report any unusual findings discovered on the oral/dental assessment to the attending physician, responsible party, and registered dietician. New interventions should be implemented as needed. The social worker should assist in appointments for on-going dental needs with the consulting dentist routinely and in the event of an emergency.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and policy review, the facility failed to ensure a resident's indwelling urinary catheter's collection bag was maintained off the floor reducing the risk of infection. This affected one resident (#44) of two residents reviewed for indwelling urinary catheters. Findings include:Review of Resident #44's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included a malignant neoplasm of an unspecified part of an unspecified bronchus or lung, malignant neoplasm of the vulva, neuromuscular dysfunction of the bladder, retention of urine, and difficulty walking. Review of Resident #44's physician's orders revealed the resident had an order to maintain an indwelling urinary catheter related to the diagnosis of retention of urine. The order had been in place since the resident was admitted to the facility on [DATE]. There was also an order to change her catheter bag every week on Tuesdays. Review of Resident #44's active care plans revealed the resident had a care plan in place for an alteration in elimination related to the use of an indwelling urinary catheter. The care plan originated on 03/18/26 and the goal was for the resident to be free from complications related to appliance use through the review date. The interventions included the need to maintain the indwelling urinary catheter bag to gravity drain. They were to keep the catheter bag below the level of the resident's bladder and to secure the catheter tubing to prevent accidental dislodgement. There were no interventions specific to maintaining the indwelling urinary catheter's collection bag off of the the floor in an effort to prevent infections. On 03/23/26 at 10:31 A.M. an observation of Resident #44 noted her to be lying in bed. Her indwelling urinary catheter's collection bag was lying directly on the floor, under the bed. It had a privacy cover on the front side of the collection bag but the back side of the collection bag was uncovered and resting on the floor. Some of the catheter's tubing leading to the collection bag was also on the floor. Findings were verified by Registered Nurse (RN) #145. On 03/23/26 at 10:32 A.M., an interview with RN #145 confirmed indwelling urinary catheter's collection bags should be maintained below the level of the resident's bladder and secured off the floor. She verbalized the need to keep it off the floor to prevent infections. She secured Resident #44's indwelling urinary catheter collection bag so it was up and off the floor by securing it to the bed frame using the clip that was attached on the top of the collection bag. On 03/24/26 at 9:25 A.M., a follow up observation of Resident #44 noted her to be up in a wheelchair in the therapy room. Her indwelling urinary catheter's collection bag was again noted to be in direct contact with the floor. The urinary catheter's tubing to the collection bag was also on the floor, underneath the wheelchair. They had the collection bag to the urinary catheter secured to the frame of the wheelchair below the seat, but it still allowed the collection bag to come into contact with the floor. Findings were verified by the facility's Director of Nursing (DON). On 03/24/26 at 9:27 A.M., an interview with the DON revealed indwelling urinary catheter bags should be maintained below the level of the resident's bladder and the tubing and collection bag should be kept off the floor. When asked what the importance was with maintaining the collection bag off the floor, she reported to prevent infection. She indicated she would secure the collection bag off the floor by putting it in a cover bag. Review of the facility's policy on Foley Catheter Care (not dated) revealed the purpose of the policy was for the facility to promote urinary health and management to the resident with an indwelling urinary catheter to provide the resident with dignity and to prevent the potential for urinary tract infection. The procedure indicated the staff were directed to position the indwelling urinary catheter bag below the level of the bladder, while keeping the bag and the tubing off the floor at all times.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview the facility failed to ensure all mechanical, electrical, and patient equipment was in safe operating condition. This affected one resident (#37) of seven residents who are dependent on mechanical lifts for transfer. The census was 37.Findings include:Medical record review revealed Resident #37 was admitted to the facility on [DATE] with diagnoses including multiple sclerosis, chronic obstructive pulmonary disease, and muscle weakness.Review of Resident #37's minimum data set (MDS) assessment completed on12/02/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Resident #37's minimum data set revealed the resident was dependent of staff for toileting, personal hygiene, and bed mobility and transfers. Observation on 03/26/26 at 8:51 A.M. revealed Resident #37 being transferred from bed to chair with a mechanical lift with Certified nurses aide (CNA) #128, and CNA#164. Upon lifting the resident from the bed, the mechanical lift stopped working, leaving Resident #37 hovering above the bed inside the mechanical lift. CNA #164 left the room to get a replacement battery.Interview on 03/26/26 at 8:55 A.M. with Resident #37 confirmed the resident is dependent on mechanical lift for transfers. Resident #37 stated almost always the lift stops working, and someone has to leave the room to get a new battery, at least half of the time. Resident #37 stated it is scary when it stops when they are in the air, you aren't sure if its going to work, what's going to happen, if its going to work [the mechanical lift]. Resident #37 stated yesterday, 03/25/26 the staff members had to change the batteries out four times on the mechanical lift before it would work.Interview on 03/26/26 at 9:03 A.M. with CNA #128 confirmed there was an issue with the mechanical lifts, they think just with the batteries, but they are unsure. CNA #128 stated during resident transfers the mechanical lifts with stop, leaving the resident in the air at times, and a staff member has to leave the room to get another battery, leaving one staff member in the room with the resident while they are in the air in the mechanical lift. CNA #128 stated they are worried a resident may get stuck or get scared.Interview on 03/26/26 at 9:10 A.M. with CNA #164 confirmed there has been a problem with the reliability of the mechanical lifts. The lifts will stop working in the middle of a resident transfer, you have to switch the batteries out, sometimes multiple times, even if they [the batteries] say they have full charge. It worries you if something is going to happen during a transfer such as a resident getting injured or you are unable to transfer them to where they need/want to go [bed, chair].