

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365594	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/23/2025
NAME OF PROVIDER OR SUPPLIER Gardens of Euclid Beach		STREET ADDRESS, CITY, STATE, ZIP CODE 16101 Euclid Beach Blvd Cleveland, OH 44110	
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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, review of emergency medical services (EMS) run report, staff interview, and facility policy review, the facility failed to initiate Cardiopulmonary Resuscitation or timely call EMS for Resident #13, a resident with advance directives for a Full Code status (indication for healthcare providers to perform all possible life-saving measures in the event of a cardiac or respiratory arrest). This resulted in Immediate Jeopardy and Actual Harm/Subsequent Death on [DATE] at 5:40 P.M. when Resident #13 was found unresponsive and Licensed Practical Nurse (LPN) #521 failed to initiate CPR. EMS was not called until [DATE] at 6:23 P.M. and arrived at the facility at 6:32 P.M. Upon arrival, EMS determined Resident #13 was deceased , CPR was not in progress by facility staff and EMS were informed Resident #13 had been pronounced deceased in the facility at 5:40 P.M. This affected one resident (#13) of ten residents reviewed for death. The facility census was 53. On [DATE] at 1:27 P.M., the Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) #615 were notified Immediate Jeopardy began on [DATE] at 5:40 P.M. when Resident #13 was found unresponsive and Licensed Practical Nurse (LPN) #521 failed to initiate CPR or timely summon EMS services. The resident, who had advance directives for a Full Code status was subsequently pronounced deceased at the facility. The Immediate Jeopardy was abated on [DATE] when the facility implemented the following corrective actions: On [DATE] at 1:00 P.M. Managerial staff, Regional Director of Clinical Services (RDCS) #601, the Administrator, and the DON met and reviewed data collaboratively. A root cause analysis was conducted and system failure identified LPN #521 did not know Resident #13's code status and did not initiate CPR. On [DATE] at 2:00 P.M. the Administrator and DON received education from [NAME] President of Clinical Services (VPCS) #618 and [NAME] President of Operations (VPO) #617 on the following topics: where to locate advanced directives, CPR policy, Code Blue Flow Sheet, that hospice was not a code status and that advanced directives still need checked. The staff were educated to check the bed board, with a new process to add code status daily for staff and contracted service providers was also provided. Staff were educated to check the bed board, change of condition, communication during a code the crash cart, and staffing assignments. On [DATE] at 3:00 P.M. an Ad Hoc Quality Assurance and Performance Improvement (QAPI) was held. The meeting was held with the Administrator, the DON, Minimum Data Set (MDS) Coordinator #613, Medical Director (MD) #614, Dietary Director #602, Social Services Director #557, Medical Records #582, Activity Director #513, ADON #615, Human Resources Director (HRD) #520, Director of Rehabilitation (DoR) #565, Wound Care LPN #603, and Environmental Services Director (ESD) #550. The Administrator and the DON educated management on where to locate advanced directives, the facility CPR policy, Code Blue Flow Sheet, that hospice was not a code status and that advanced directives still needed checked, and new bed board process to add code status daily for staff. Contracted service providers would be educated to check the bed board, change of condition, communication during a code, crash cart, and staffing assignments. A Root Cause analysis was reviewed. The facility would give each service provider a memo upon entering the building that stated the facility's new process, they were to sign off on the sign off sheet that they (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 0684 Level of Harm - Immediate jeopardy to resident health or safety 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 observation, closed record review, review of emergency medical services (EMS) run reports, review of the facility assessment and floor plan, review of facility staffing, policy review and interview, the facility failed to accurately assess and provide timely and necessary medical intervention for residents identified to have an acute change in condition. In addition, the facility failed to provide basic life support (BLS) and Cardiopulmonary Resuscitation (CPR) in accordance with BLS/CPR standards of practice, failed to maintain adequate staffing resources to allow for efficient and effective emergency response to residents' with cardiopulmonary arrest, and failed to have effective systems in place for staff to obtain timely assistance during a CPR code. This resulted in Immediate Jeopardy and Actual Harm/Subsequent Death for Resident #13, #58 and #74. This affected three residents (#13, #58, and #74) of 22 residents reviewed for change in condition. The facility census was 53. Immediate Jeopardy began on [DATE] at approximately 12:30 A.M. when Resident #74 was assessed to have shortness of breath with a low oxygen saturation (71%). The nurse on duty failed to notify the physician or provide adequate intervention. The resident's oxygen saturation remained low (85% and 89%) when checked following the administration of aerosol treatment and application of Bilevel Positive Airway Pressure (BiPAP) (a noninvasive ventilation system to administer supplemental oxygen) with no evidence of physician notification or medical intervention. At approximately 2:10 A.M. the resident was found on the floor of his room. Licensed Practical Nurse (LPN) #532 began CPR per the resident's advance directives; however, the LPN did not check to see if the resident had a pulse prior to implementation. The other nurse on duty (LPN #633) took over 30 minutes to call 911 causing a delay in emergency medical services (EMS) response/assistance. EMS arrived at the facility at 2:57 A.M. and transported Resident #74 to a local hospital where he was pronounced deceased on arrival at the emergency room (ER) at 3:33 A.M. The Immediate Jeopardy continued on [DATE] when Resident #58 told Registered Nurse (RN) #511 she was having respiratory distress. RN #511 did not check the resident's vital signs before administering treatment and then left the resident unattended to get oxygen. When RN #511 returned, Resident #58 was unresponsive. Without assessing the resident's vital signs, RN #511 again left the resident to go to another floor to get help. Upon return to the resident's room, CPR was initiated without first assessing to see if the resident had a pulse and without use of a backboard (a necessary component to CPR which provides a firm, non-compressible surface and reduces mattress displacement allowing for effective compressions). EMS arrived onsite and took over CPR at 3:10 A.M. Resident #58 was subsequently pronounced deceased on arrival at the emergency room (ER) at 3:45 A.M. The unit Resident #58 resided on at the facility had just opened in [DATE] with single occupancy rooms for skilled residents. There was no staffing plan for this unit in the facility assessment. In addition, there was no communication system in place for emergent situations and staff working on the unit had to physically leave the unit to go to the second floor to get additional staff assistance when/if needed. The Immediate Jeopardy continued on [DATE] at 1:04 P.M. when LPN #506 failed to notify Medical Director (MD) #614 or provide medical intervention when Resident #13, (who had advance directives for a Full Code status) was assessed to have an acute change in medical condition. The resident had coffee ground emesis, was hypotensive (blood pressure of 87/60 (normal ranges from 120/80)), tachycardic (pulse of 114 (normal ranges from 60 to 100 beats per minute (bpm))), and an oxygenation level of 93 percent (%) (normal ranges from 95 to 100%) on room air. At 5:40 P.M., Resident #13 was found unresponsive with no intervention provided. EMS were not contacted until [DATE] at 6:23 P.M. and arrived at the facility at 6:32 P.M. Upon arrival, EMS determined Resident #13 was deceased, CPR was not in progress by facility staff, and EMS was informed that Resident #13 had been pronounced deceased at the facility at 5:40 P.M. On [DATE] at 4:20 P.M. the Director of Nursing (DON), Administrator, Regional Director of Clinical Services (RDCS) #601, and Regional Director of (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Operations (RDO) #559 were notified Immediate Jeopardy began on [DATE] at 2:10 A.M., when the facility failed to ensure comprehensive systems were in place to timely identify and provide necessary intervention to Resident #74 who experienced an acute change in condition resulting in the resident's death. The Immediate Jeopardy continued on [DATE] and [DATE] when the facility continued to ensure comprehensive systems were in place to timely identify and provide necessary intervention to residents (#58 and #13) who experienced an acute change in condition resulting in resident death. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: On [DATE] at 4:30 P.M. during a TEAMS (virtual) call with [NAME] President of Operations (VPO) #617, [NAME] President of Clinical Services (VPCS) #618 educated the Administrator, DON, RDCS #601, and RDO #599, on the facility CPR policy, emergency response processes, and code blue flow sheets related to how to respond to emergency situations and to notify others for help by use of walkie-talkie or overhead paging system. On [DATE] at 5:00 P.M., RDCS #601 and the Administrator provided education to Activities Director (AD) #513, Housekeeping Services Director (HSD) #550, the DON, the Assistant Director of Nursing (ADON) #615, Medical Records Director (MRD) #582, Maintenance Director #538, Director of Social Services (DSS) #557, Minimum Data Set Director (MDSD) #613, Dietary Manager (DM) #602, Human Resources Director (HRD) #520, and Wound Care Nurse (WCN) #603, on the CPR policy, emergency response processes, and code blue flow sheets related to how to respond to emergency situations and to notify others for help by use of walkie-talkie or overhead paging system. On [DATE] at 5:45 P.M. an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was led by RDCS #601 and the Administrator who identified the root cause analysis to be lack of education on the facility CPR policy and emergency response/notification protocols. The members in attendance were identified to be AD #513, HSD #550, the DON, ADON #615, MRD #582, Maintenance Director #538, DSS #557, MDSD #613, DM #602, HRD #520, WCN #603 and Medical Director (MD) #614 via the telephone. On [DATE] at 6:45 P.M. RDCS #601 and RDO #599 educated all staff (32 Certified Nursing Assistants (CNAs), 19 LPNs, four RNs, seven housekeeping staff, six receptionists, 16 therapists, and two activities staff) on the facility CPR policy, emergency response processes, and code blue flow sheets related to how to respond to emergency situations and to notify others for help. On [DATE] by 5:30 P.M. all 58 residents were assessed by the DON, WCN #603, and ADON #615 for any acute changes in condition. On [DATE] starting at 5:00 P.M., Corporate RN Basic Life Support Instructor #619 and Corporate LPN Basic Life Support Instructor provided CPR recertification to nine nurses (LPN #551, ADON #615, the DON, LPN #521, LPN #559, LPN #510, WCN #603, LPN #607, and LPN #504). All nurses who did not attend were removed from the schedule until they were able to provide updated CPR recertification. On [DATE] at 4:30 P.M., RDCS #601 conducted an audit on crash carts to ensure they were stocked and readily available for an emergency situation. On [DATE] at 6:00 P.M. all clinical staff (32 CNAs, 19 LPNs, and 4 RNs), received education by RDCS #601 and Former DON (FDON) #604 validating that code statuses were updated. Three resident orders (Resident #87, Resident #60, and Resident #23) were updated for code statuses. On [DATE] at 6:15 P.M., VPO #617, VPC #618, RDCS #601, RDO #599, the Administrator, and the DON met to discuss future staffing for when closed units opened. Beginning on [DATE], RDCS #601 initiated education to all clinical staff, also to include scheduler/HR, DON and the Administrator, to ensure there was always a minimum of one staff member on the first floor. On [DATE], the DON/Designee would perform mock code blues on alternating shifts five times a week for four weeks, then weekly on alternating shifts for four weeks. Audits would be documented on the code blue flow sheet. All audits performed would be recorded and reviewed during the weekly QAPI. Beginning on [DATE], CPR policy training would be conducted during new hire orientation and every six months with staff. The DON would be responsible to ensure that all new hires received the information during new hire orientation and would monitor the education (related to the CPR policy, emergency response processes, and code blue flow sheets on how to respond to emergency situations and to notify others for help) every six months. Beginning on (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	revised on [DATE] revealed to implement full code measures per the resident's request. Review of a nursing progress note for Resident #74 dated [DATE] at 4:00 A.M. revealed LPN #532 documented at the start of her shift the resident was alert and oriented. At approximately 12:30 A.M., Resident #74 was lying flat. LPN #532 elevated the resident's head of the bed and checked his oxygen level. The resident's oxygen level was 71% (abnormal low). LPN #532 had Resident #74 use his as needed Ventolin and Ipratropium aerosol for shortness of breath. Upon completion of the breathing treatment, LPN #532 re-checked the resident's oxygen level, and it had increased to 85% (which remained below normal range). The note included LPN #532 applied the resident's BiPAP around 1:00 A.M. then re-checked his oxygen level after using it for a short while, and his oxygen level increased to 89% (remained below normal range). There was no evidence the physician was notified or evidence of adequate intervention to address this change in the resident's condition. Continued review of the nursing progress note authored by LPN #532 revealed at 2:10 A.M., LPN #532 went to check on Resident #74 and was met in the hallway by Resident #74's roommate who informed the nurse that Resident #74 was on the floor. The progress note revealed LPN #532 immediately began CPR with CNA #610 assisting with the code. The CNA re-applied Resident #74's oxygen. The note included at 2:38 A.M., 911 (EMS) was called to transport the resident to the hospital. CPR continued until EMS arrived and took over care. LPN #532 notified the Director of Nursing (DON), the Assistant Director of Nursing (ADON) the Medical Director (MD), and the resident's next of kin regarding what happened and his transport to the local emergency room (ER). LPN #532 documented on [DATE] at 4:28 A.M. that she contacted the ER and was informed Resident #74 had passed away. Review of the EMS Run Report, dated [DATE], revealed EMS received a call from the facility at 2:44 A.M. and arrived at the facility at 2:57 A.M. Resident #74 was found by EMS with CPR being performed on the floor by facility staff. After EMS arrived, they confirmed asystole (no pulse) on a monitor, they took over CPR and transported Resident #74 to the local hospital emergency room where he was pronounced dead on arrival at 3:33 A.M. An interview with LPN #532 on [DATE] at 4:09 P.M. revealed she always worked the night shift from 11:00 P.M. to 7:00 A.M. and she was typically assigned to work on the second floor. She verified she was the nurse assigned to care for Resident #74 on ([DATE]) the night the resident coded and passed away. LPN #532 stated on this night she had the resident sit up on the edge of his bed, she gave him his inhaler and then breathing treatment for shortness of breath. LPN #532 stated she felt Resident #74 was feeling better after his breathing treatment. LPN #532 said about an hour later she went to see how the resident was feeling and was informed by Resident #74's roommate that the resident was on the floor. LPN #532 said she yelled for help immediately and CNA #610 said she was CPR certified and offered to help. LPN #532 said she did not check to see if Resident #74 had a pulse, she just started CPR. LPN #532 stated that LPN #633 called 911 but it took LPN #633 30 minutes before she called 911 for emergency services. LPN #532 stated she did not know why it took LPN #633 so long to call 911. LPN #532 stated she later contacted the hospital and was told Resident #74 had expired. LPN #532 stated she was orienting LPN #633 that shift, and LPN #633 brought the crash cart to Resident #74's room. During the interview LPN #532 stated LPN #633 and CNA #610 no longer worked at the facility but did not provide any additional information related to why. An interview on [DATE] at 11:35 A.M. with Medical Director (MD) #614 revealed EMS should be called immediately for any resident who goes into cardiac arrest. Medical Director #614 also stated the nurse should check for a pulse before starting CPR. A telephone interview with LPN #633 on [DATE] at 6:49 P.M. revealed she had only worked for the facility for a few weeks. During the interview, she stated she remembered the night of [DATE] when Resident #74 coded as stated it was very frightening. LPN #532 had yelled for help after the LPN had found the resident on the floor. CNA #610 was assisting LPN #532, so LPN #633 stated she went back to the nurses' station to try and find information about the resident so she could call for help. LPN #633 said she tried to call 911 but was unable to figure out how to use the facility phone. LPN #633 said she finally used her personal phone to call 911. LPN #633 said she did not know the address of the facility to provide to EMS. LPN (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	#579 then went to the elevator and returned to the first floor. CNA #579 verified the first floor had been left without a staff member while she was on the second floor. On [DATE] at approximately 2:00 P.M. observation of the room Resident #58 had occupied revealed it was at the very end of the hallway farthest away from the elevator. In order for RN #511 to get help from the second floor, she walked 137.5 feet from the resident's bed to the first floor elevator, pushed the button to call the elevator, waited (an unknown amount of time) for the elevator to arrive, ascend to the second floor and locate the staff for help, then return to the resident's room. This distance was verified by Administrator #600 and Regional Director of Clinical Services #601 during an interview on [DATE] at 12:15 P.M. LPN #532, who was the nurse assigned to the second floor during interview as part of the on-site investigation stated she would estimate it would have taken two to three minutes for RN #511 to obtain assistance for Resident #58. Interview with the Director of Nursing (DON) on [DATE] at 11:25 A.M. revealed she had worked for the facility for several years as a night shift supervisor but had only been the DON for a few weeks. She stated the nurse assigned to the first floor also had residents assigned to her on the second floor and the facility recently (date not provided) changed staffing to always have a CNA working on the first floor. If an emergency were to occur, the CNA would call for help. The CNA could overhead page for help but most likely they would run to the second floor for help. Interview with RN #517 on [DATE] at 2:50 P.M. revealed she had worked for the facility for approximately one month. RN #517 was not aware the facility was supposed to have a code team consisting of one nurse and two CNAs and she was not aware the facility had a code blue documentation sheet. She further stated she received no information during orientation regarding mock code exercises. Interview with LPN #521 on [DATE] at 2:55 P.M. revealed she had worked for the facility for approximately one month. LPN #521 was not aware the facility was supposed to have a code team consisting of one nurse and two CNAs and she was not aware the facility had a code blue documentation sheet. She further stated she received no information during orientation regarding mock code exercises. Interviews with CNA #563 and CNA #523 on [DATE] at 3:05 P.M. revealed neither one was aware that there was a CPR team on each shift or that they were to be assigned to it. CNA #563 said she was certified in CPR for another facility and CNA #523 said she used to be CPR certified through the facility when they offered it, but it expired a few years ago. Interview with Former DON (FDON) #604 on [DATE] at 3:10 P.M. revealed she was unaware the facility was supposed to have a CPR team on each shift and revealed the CNA staff were not CPR certified. FDON #604 stated the facility did not have a crash cart policy and she had never seen a code blue documentation sheet. FDON #604 stated the facility had not yet come up with a plan regarding how the first-floor staff were to obtain help since the incident with Resident #58 had just occurred and they had not had time to determine how to fix the problem. The FDON stated they always had the capability of overhead paging and thought everyone knew how to do that. FDON further revealed that RN #511 should not have had to leave an unresponsive resident to obtain help. Interview with RDO #599 on [DATE] at 3:30 P.M. revealed she was unaware of the facility's CPR policy indicating there was a code team assigned to each shift consisting of one nurse and two CNAs and that the CNAs were not certified in CPR. She was unable to provide any information on mock code in-services. Interview with RN #511 on [DATE] at 4:30 P.M. revealed she was assigned to the first floor on [DATE]. She stated she preferred to be the one assigned to the first floor as opposed to an aide as she felt a nurse should be the first line of defense for the building. RN #511 confirmed she was also assigned residents on the second floor as well. During the interview, RN #511 revealed on [DATE] Resident #58 had activated her call light, and she went to her room to see what the resident needed. The resident said she was short of breath. RN #511 elevated the head of the resident's bed then went to the medication cart and brought the resident's Albuterol inhaler to use. The resident inhaled two puffs. Before RN #511 was able to leave the room, Resident #58 stated the inhaler was not helping and requested an aerosol treatment. RN #511 obtained the resident's Albuterol-Budesonide aerosol 90-80 micrograms and started the aerosol treatment. Resident #58 then requested oxygen be (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	obtained. There was no evidence the RN conducted a comprehensive assessment (including vital signs or physical respiratory assessment) of the resident during this time Continued interview with RN #511 revealed she then left the first floor, went up to the second floor, and retrieved an oxygen concentrator and oxygen tubing which she then took back down to the resident's room. RN #511 stated she had left Resident #58 sitting up in bed when she went to get the oxygen and when she returned to the room, RN #511 found the resident lying on the bed. RN #511 said she nudged the resident, but nothing happened, and the resident did not respond. RN #511 said she was the only person working on the floor, so she had to leave the resident's room, go to the elevator, push the button for the elevator, take the elevator to the second floor then yell for help. The RN revealed LPN #532 and an unidentified aide came to RN #511's assistance and they returned to the first floor. When asked if there was any other way to obtain help, RN #511 reported no, she was not able to overhead page and stated staff had had requested walkie talkies in order to obtain assistance from the second floor, but nothing had come from it. RN #511 also revealed the facility did not have an AED to use on a resident who went into cardiac arrest. RN #511 said she and LPN #532 took the crash cart to Resident #58's room and the unidentified aide called 911. Upon entering Resident #58's room, RN #511 stated she and LPN #532 began CPR with the resident. The RN revealed they did not place a backboard under the resident. RN #511 stated prior to initiating CPR she did not check for a pulse, and the facility did not have an AED to determine if a resident required a shock to restart her heart. RN #511 said she and LPN #532 continued CPR until EMS arrived at which time the resident was transferred to the local ER. RN #511 said the evening shift nurse, LPN #544, had not reported anything unusual about Resident #58 at the earlier change of shift. Interview with LPN #532 on [DATE] at 4:09 P.M. revealed she was typically assigned to work on the second floor. During the interview LPN #532 revealed she remembered when Resident #58 coded. LPN #532 said the resident was in respiratory distress and RN #511 gave her an inhaler, then an aerosol treatment, then had to retrieve oxygen the resident wanted from the second floor. LPN #532 said the next thing she knew RN #511 returned to the second floor calling for help. LPN #532 said she and an unidentified aide went back to the first floor with RN #511. RN #511 and LPN #532 grabbed the crash cart and went to the resident's room while the aide called 911. LPN #532 said she thought Resident #58 had a pulse still as the pulse oximeter was picking up an oxygenation level. She stated RN #511 did not check for a pulse before starting CPR. LPN #532 said CPR continued until EMS arrived and took over. They transported Resident #58 to the ER where she was pronounced expired. Interview with DoR #565 on [DATE] at 10:50 A.M. revealed he had worked with Resident #58 on [DATE] and denied the resident had any concerns, complaints of shortness of breath, not feeling well, or chest pain. The DoR revealed the resident presented as per her normal and there was nothing out of the ordinary with the resident. The DoR revealed he was surprised when he heard the next day the resident had passed away. Interview with LPN #510 on [DATE] at 11:15 A.M. revealed she recalled Resident #58. The LPN revealed the resident was on the first floor in the new unit that opened sometime in [DATE]. LPN #510 said the resident was alert, independently mobile, and knew what she wanted. Resident #58 never complained about being short of breath, not feeling well, or chest pain. Interview with MD #614 on [DATE] at 11:35 A.M. revealed he was the only physician for the [TRUNCATED]		

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NAME OF PROVIDER OR SUPPLIER Gardens of Euclid Beach		STREET ADDRESS, CITY, STATE, ZIP CODE 16101 Euclid Beach Blvd Cleveland, OH 44110	
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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, pest control invoice reviews, staff interview and facility policy review, the facility failed to dispose of garbage in a clean and sanitary manner. This had the potential to affect all 53 residents residing in the facility. Findings include: Observation on 08/18/25 at 9:47 A.M. with Regional Dietary Manager #598 revealed the outside facility dumpster area had three dumpsters with the lids closed. The area surrounding the dumpsters revealed loose debris including incontinence care items, used gloves and various loose trash scattered around on the ground around the dumpsters. Interview at the time of the observation with Regional Dietary Manager #598 confirmed the observation of trash on the ground surrounding the dumpster. Review of the facility pest control invoice dated 07/10/25 revealed noted sanitation issues including loose food debris found in the garbage area due to spilled food materials on the ground and could cause pest problems. Review of the facility pest control invoice dated 08/04/25 revealed the exterior garbage area trash can had loose food debris surrounding the area and could cause pest problems. Review of the facility policy called; Sanitization, revised October 2008, revealed all kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects. Kitchen waste that is not disposed of by mechanical means shall be kept in clean, leakproof, nonabsorbent tightly closed containers and shall be disposed of daily.		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation, record review, job description review, and interview, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This had the potential to affect all residents residing in the facility. The facility census was 53. Findings include: A review of the facility job description labeled Administrator revealed the purpose of the position was to establish and maintain systems that were effective and efficient to operate the facility in a manner to safely meet the residents' needs in compliance with federal, state, and local requirements. The job description further stated the administrator would determine the personnel requirements of the facility and hire or arrange for sufficient staff to implement the facility policies and procedures. The administrator would develop a monitoring system to assure compliance with federal, state and local requirements. Specific requirements were as follows: Established systems to enforce the facility policies and procedures Establish written personnel policies and individual job descriptions Supervise all department supervisors and administrative staff Develop one-to-one relationships with residents and families Assume responsibility for ensuring that equipment is in operating orderA review of the facility job description labeled Director of Nursing (DON) revealed the purpose of the position was to provide nursing management, set resident care standards for all direct care providers and provide complete supervision and management of the nursing department. The job description further stated the Director of Nursing would assess resident needs and interview, hire and terminate adequate nursing personnel, set resident care standards in accordance with accepted current standards of care to provide high quality of care to residents, supervise and manage all aspects of the nursing department and assess direct and supervise residents' care needs.A review of the facility job description labeled Maintenance Supervisor revealed the purpose of the position was to develop and implement facility maintenance policies and procedures. The job description further stated the Maintenance Supervisor shall develop and implement a monitoring system for the maintenance department and make recommendations for implementation to assure compliance with federal, state and local requirements. The Maintenance Supervisor would supervise the entire operation of the maintenance department. On 08/18/25 at 9:36 A.M. an interview with the Regional Director of Operations (RDO) #599, Licensed Nursing Home Administrator (LNHA) #600 and Director of Clinical Services #601 revealed LNHA #600 had been at the position for one week. The interview further revealed there had been six previous administrators over the past year. RDO #559 stated the Director of Nursing was new in the position as well. RDO #559 stated the previous administrator and director of nursing were transferred to a sister facility 08/13/25.A review of an email from [NAME] President of Operations #617 to RDO #599 dated 08/18/25 with the subject listed as Euclid Administrators revealed a total of seven LNHA's in the last year. LNHA #631 from 03/20/24 to 08/25/24 LNHA #630 from 08/26/24 to 11/25/24 LNHA #629 from 11/25/24 to 02/11/25 LNHA #628 from 02/12/25 to 07/14/25 LNHA #627 from 07/14/25 to 08/09/25 LNHA #626 from 08/09/25 to 08/13/25 and LNHA #600 from 08/13/25 through current.A review of a document titled; Director List for the Last Year revealed there were four DONs in the last year: Registered Nurse (RN) #623 from 02/01/24 to 03/10/25 RN #622 from 03/10/25 to 04/07/25 RN #604 from 04/07/25 to 08/11/25 and RN #581 from 08/10/25 through current.A review of a document titled; Maintenance Directors revealed three Maintenance Directors in the last year: Maintenance Director (MD) #624 from 04/15/24 to 05/31/25 MD #625 from 05/22/25 to 08/09/25 and MD #538 from 08/09/25 through current.During the annual and complaint surveys, observations, record reviews, and interviews, resulted in concerns related to the overall operation of the facility including but not limited to, care planning, environmental and equipment concerns, activities of daily living care, treatment to maintain vision, laboratory services, accurate facility assessment, documentation issues, staff orientation and training, quality assurance committee, resident food storage, accident prevention, infection control regarding oxygen (continued on next page)		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	tubing, pharmacy reviews, food storage, dignity, quality of care and medication storage. The facility failed to provide evidence that administrative staff, including the Administrator and/or DON, had effective systems in place to timely identify and correct quality, care and environmental concerns. A. The facility failed to ensure an accurate care plan was indicative of oxygen use for one resident (Resident #55) of three reviewed for oxygen use. B. The facility failed to ensure a clean and sanitary homelike environment and failed to ensure garbage was disposed of properly. This had the potential to affect all residents residing in the facility.C. The facility failed to initiate Cardiopulmonary Resuscitation (CPR) or call emergency medical services (EMS) for Resident #13 resulting in immediate jeopardy and death. D. The facility failed to ensure showers/bathing was completed and documented as required for twelve residents (Residents #1 #2, #3, #5, #7, #29, #41, #44, #45, #53, and #63) of 44 residents who required staff assistance for showers and bathing.E. The facility failed to ensure physician ordered labs were completed timely for Resident #53.F. The facility failed to ensure medical record documentation included weekly skin assessments as ordered and care planned for 11 residents (#1, #3, #7, #9, #29, #44, #45, #49, #53, #63, and #69) and failed to ensure the change of condition and subsequent death of Resident #76 was documented in the medical record. This affected 12 residents (#1, #3, #7, #9, #29, #44, #45, #49, #53, #63, #69 and #76) of 22 residents reviewed for complete resident records.G. The facility failed to have an updated and accurate facility assessment to indicate sufficient staffing for the first floor. This had the potential to affect six residents identified as residing on the first floor (Residents #22, #26, #31, #35, #46 and #61).H. The facility failed to ensure Resident #29 was provided corrective lens and vision care appointments per physician orders.I. The facility failed to ensure a complete orientation of new certified nurse assistants and licensed nurses. This had the potential to affect all residents residing in the facility.J. The facility failed to ensure sufficient competent staffing on the first floor which had the potential to affect six residents (#22, #26, #31, #35, #46 and #61) who resided on the first floor of the facility.K. The facility failed to ensure quality assurance team consisted of the required members. This had the potential to affect all residents living in the facility.L. The facility failed to ensure resident personal refrigerators were monitored for temperatures and food spoilage.M. The facility failed to ensure appropriate supervision during smoking times and failed to ensure residents did not have smoking items in their personal possession which affected Resident #45 and #49.N. The facility failed to ensure oxygen tubing was dated when changed for Resident #39 and #55.O. The facility failed to ensure pharmacy reviews were completed monthly for Resident #4 and #53.P. The facility failed to ensure the physician was notified of changes in condition for Resident #13 and #85.Q. The facility failed to ensure a catheter drainage bag was covered for Resident #27.R. The facility failed to ensure medications were properly secured.S. The facility failed to ensure appropriate quality of care for three residents (Resident #13, #58, and #74) resulting in immediate jeopardy and death. This deficiency represents non-compliance investigated under Complaint Numbers 2578214 and 1381901.		

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on document review and interview the facility failed to ensure its Quality Assurance and Performance Improvement (QAPI) committee consisted of the required members. This had the potential to affect all residents residing in the facility. The facility census was 53. Findings include: A review of the document titled; Euclid Beach QAPI Members that was undated revealed the committee is made up of the following members: Committee Chairperson Administrator Director of Nursing Medical Director Dietary Representative Pharmacy Representative Social Service Representative Activities Representative Environmental Service Representative Infection Control Representative Rehabilitative/Restorative Services Representative Staff Development Representative Safety Representative and Medical Records Representative. A review of a document titled; QAPI Plan dated 01/30/25 revealed a QAPI Meeting was held. The document further revealed the meeting was attended by Licensed Nursing Home Administrator (LNHA) #629 and Director of Nursing #623. There was no indication or sign in sheet to verify the meeting was attended by the Medical Director or Infection Control Representative. A review of the document titled; Quality Assurance and Performance Improvement Meeting dated 03/25/25 revealed there was no representative for infection control. The sign in sheet was void of a signature for infection control. The infection control portion of the document was blank. A review of the document titled; Ad-Hoc QAPI Committee Meeting dated 05/29/25 revealed no signature for the Medical Director indicating attendance. There was no representative for infection control noted on the sign in sheet indicating attendance. On 09/02/25 at 12:29 P.M. an interview with Regional Director of Operations (RDO) #599 verified the lack of an Infection Control Preventionist at the QAPI meetings dated 01/30/25, 03/25/25 and 05/29/25. RDO #599 also verified the absence of the Medical Director at the QAPI meetings dated 01/30/25 and 05/29/25.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review, the facility failed to ensure a clean and sanitary homelike environment was provided for residents. This had the potential to affect all residents residing in the facility. The facility census was 53. Findings include: On 08/18/25 between 12:00 P.M. and 1:45 P.M. an initial observational tour of the building was conducted. room [ROOM NUMBER] was noted to have peeling wallpaper and a missing corner piece protector on the left side of the wall between the television stand and the bathroom that exposed the bare wall. The bathroom floor was noted to be coming up. A piece of vinyl approximately six foot by five foot was noted on the bathroom wall across from the toilet that was curved onto the left side of the wall. The toilet was noted to be dirty. There were two full urinals hanging off the garbage can by the bed. There were gnats crawling at the sink and in a wash basin. The aforementioned was verified by Housekeeping and Laundry Supervisor #550 at the time of the observation. room [ROOM NUMBER] was noted to have a ceiling tile with a large brown stain on it that appeared to be wet. Resident #31 stated it was reported to the Administrator several days ago and maintenance came to fix it. Resident #31 further stated the ceiling tile was replaced but the pipes were not looked at as to a possible cause. On 08/19/25 at 10:35 A.M. peeling wallpaper by the second-floor elevator exposing the wall was noted. room [ROOM NUMBER] was noted to have visible rust around the sink in the room. The wall between the door and the sink was noted to have gouges and large black scuffs on it. The aforementioned was verified by [NAME] President of Plant Operations (VPO) #605 and Maintenance Director (MD) #538 at the time of the observation. VPO #605 also verified the bathroom wall damage in room [ROOM NUMBER] noted on 08/18/25. VPO #605 stated the curving piece of vinyl that was placed on the wall across from the toilet was not a proper fix for possible wall damage. VPO #605 stated the vinyl sheet should have been cut and pieced at the corner. Further interview with VPO #605 revealed there are no regular cite visits by him in regard to general upkeep and cleanliness of the building. VPO #605 stated a mock survey was conducted in April of this year and a general inspection was in July. An interview with MD #538 revealed he was only in his role for two weeks. On 08/19/25 at 11:30 A.M. an interview with Regional Director of Operations (RDO) #599 revealed room rounds are done and recorded on Room Round sheets. On 08/27/25 between 10:00 A.M. and 11:15 A.M. an extensive tour of the building was conducted with the following findings: A brown stained ceiling tile in the bathroom of room [ROOM NUMBER] was noted and verified by Certified Nurse Assistant #621. room [ROOM NUMBER] was noted to have visible dirt and debris behind the door extending outward to be visible on the other side of the door. room [ROOM NUMBER] was noted to have visible dirt and debris behind the door extending outward to be visible on the other side of the door and the window curtains were not hung correctly. room [ROOM NUMBER] was noted to have visible dirt and debris behind the door extending outward to be visible on the other side of the door. The toilet was not clean with visible dirt under the inner rim. A built up dirt ring was noted within the toilet bowl. room [ROOM NUMBER] was noted to have a large dried red substance on the floor that appeared to be sauce. The privacy curtain was soiled. room [ROOM NUMBER] had a gouged and damaged wall between the television stand and the bathroom. room [ROOM NUMBER] was noted to have chipped tile on the floor. Peeling paint was noted by the baseboard and closet door. There was no baseboard between the television stand and the bathroom. The wall was exposed. room [ROOM NUMBER] was noted to have peeling paint on the wall. There was no baseboard on the wall between the closet and door exposing the wall. The top of the heating unit had built up visible dirt. room [ROOM NUMBER] had built up visible dirt on the heating unit. The bathroom had peeling wall paper with exposed wall to the left of the sink. There was visible dirt on top of the backsplash of the bathroom sink. room [ROOM NUMBER] had visible dirt and debris behind the door. room [ROOM NUMBER] had visible dirt and debris behind the door. room [ROOM (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	NUMBER] had visible dirt and debris behind the door. There was no baseboard between the entry door and the closet. The wall was exposed with a hole in it. The privacy curtain was not hung correctly. room [ROOM NUMBER] had peeling wallpaper Above the closet and below the sink. The privacy curtain was torn. The baseboard between the sink and closet was coming off. The window curtains were not hung correctly. There was rust noted around the sink. Built up dirt and debris was noted behind the entry door and coming out from under the closet. There was built up dust on top of the heating unit. room [ROOM NUMBER] was noted to have a privacy curtain that was not hung correctly. There was wall damage noted to the left of the entry door in the hall between the lower rail and baseboard. room [ROOM NUMBER] was noted to have wall damage to the lower wall between the television stand and the bathroom. room [ROOM NUMBER] was noted to have a heating unit without a cover on it. There was wall damage between the television stand and the bathroom. room [ROOM NUMBER] was noted to have peeling wallpaper. There was visible dirt and debris behind the door. room [ROOM NUMBER] was noted to have peeling wallpaper. room [ROOM NUMBER] was noted to have window curtains not hung correctly. There was peeling wallpaper on the lower right hand corner of the wall between the bathroom and the door. room [ROOM NUMBER] was noted to have build up visible dirt behind the door. There was built up visible dirt on top of the heating unit. The back left wall of the bathroom was noted to have no wallpaper and wall damage. The aforementioned was verified by Housekeeping and Laundry Supervisor #550 at the time of the observations. On 08/27/25 at 10:40 A.M. an interview with Housekeeper #575 revealed the department was short-staffed and deep cleaning of resident rooms had not been done. A review of the documents titled; Room Rounds dated 07/01/25, 07/02/25, 07/03/25, 07/07/25, and 07/14/25 revealed multiple issues with wallpaper and housekeeping. On 08/19/25 at 11:30 A.M. RDO #599 verified the dates for July 1st, 2nd, 3rd, 7th and 14th and no further room checks after 07/14/25. RDO #599 was unable to say how often room rounds were conducted as she was new to the position. A review of the document titled; Gardens of Euclid Beach TELS Mock survey dated 04/08/25 revealed The overall appearance of the facility including condition of the roof and obstructed doorways was a work in progress. Renovation was noted to be in progress. Landscaping beds were not welcoming and not kept up. A fence in the front of the building was noted to be not in good repair. There was trash noted along the back of the building. A review of an email dated 07/17/25 to VPO #605 and Licensed Nursing Home Administrator #627 revealed there was a bulk of cosmetic stuff in the building that can be fixed with mud and paint. The email further revealed the TELS system (a system for logging needed building repairs) should be addressed daily. A review of an untitled document that was identified as the deep cleaning schedule by RDO #599 revealed rooms are to be deep cleaned weekly. There was no cleaning schedule noted for deep cleaning for the units on the first floor. A review of the document titled; daily room cleaning checklist that was undated revealed The toilet seat is to be clean and sanitized and the outer bowl of the toilet is to be cleaned down to the floor. The underside of the toilet seat and inner bowl of the toilet is to be cleaned. The room is to be spot swept for large trash and food items. Sweep behind and under beds and furniture as well as possible. The room and bathroom is to be mopped in its entirety starting from the window wall and working to the entry door. A review of the policy titled; Quality of Life-Homelike Environment dated 05/2017 Revealed residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use personal belongings to the extent possible. The facility staff and management shall maximize to the extent possible the characteristics of the facility that reflect A personalized, home like setting. These characteristics include a clean sanitary and orderly environment. This deficiency represents non-compliance investigated under Complaint Numbers 2578215, 2578214, 1381903, 1381901, and 1381896.		

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on personnel file record review, interview, and facility policy review, the facility failed to ensure a complete orientation, including applicable training and facility-specific policies, was provided to newly hired Certified Nursing Assistants (CNAs) and licensed nurses. This had the potential to affect all residents residing in the facility. The facility census was 53. Findings include: On 08/26/25 at 1:35 P.M. a review of personnel files was conducted with Human Resource Director (HRD) #520. A review of the personnel file for Certified Nurse Assistant (CNA) #545 revealed a date of hire (DOH) of 07/01/24. There was no completed clinical nursing assistant orientation form within the personnel file. A review of the personnel file for CNA #568 revealed a DOH of 05/24/25. There was no completed clinical nursing assistant orientation form within the personnel file. A review of the personnel file for CNA #558 revealed a DOH of 05/24/25. There was no completed clinical nursing assistant orientation form within the personnel file. HRD #520 verified the lack of clinical nursing assistant orientation forms in the personnel files for CNAs #545, #568 and #558 at the time of the personnel file reviews. HRD #520 stated the forms do not get turned in. On 08/28/25 at 3:00 P.M. further review of personnel files was conducted. A review of the personnel file for Licensed Practical Nurse (LPN) #611 revealed a DOH of 03/28/25. There was no charge nurse orientation completed within the personnel file. A review of the personnel file for LPN #633 revealed a DOH of 04/22/25. There was no charge nurse orientation completed within the personnel file. A review of the personnel file for LPN #532 revealed a DOH of 04/02/25. There was no charge nurse orientation completed within the personnel file. A review of the personnel file for LPN #634 revealed a DOH of 04/02/25. There was no charge nurse orientation completed within the personnel file. A review of the personnel file for Registered Nurse #511 revealed a DOH of 12/06/24. There was no charge nurse orientation completed within the personnel file. HRD #520 verified the lack of charge nurse orientation forms for LPNs #611, #633, #532, #634 and Registered Nurse #511 at the time of the personnel file review on 08/28/25. HRD #520 stated the charge nurse job description was used for Registered Nurses. HRD #520 also stated the charge nurse orientation form was used as guidance for all nurses in the facility. A review of the document titled; Job Description and Performance Standards-Staff Nurse LPN dated 01/07/10 revealed the LPN will participate in facility educational programs including but not limited to orientation, in-service and nursing education. A review of the document titled; Job Description and Performance Standards-Charge Nurse dated 01/07/10 revealed the nurse will participate in facility educational programs including but not limited to orientation, in-service and nursing education. A review of the document titled; Job Description and Performance Standards-Certified nursing assistant dated 01/07/10 revealed The CNA will attend all in-service classes as assigned and complete assignments. A review of the document titled; Clinical Nursing Assistant Orientation Program that was undated revealed The mentor of the new nursing assistant will provide orientation of tasks as part of the on the floor competency. During the shadowing process, the nursing assistant mentoring the new employee will provide the date the orientation was performed. The document also revealed a signature line for the Director of Nursing for the completion of orientation and competencies. A review of the document titled; Charge Nurse Orientation that was undated revealed a signature line for the director of nursing to sign off upon completion.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review, staff and resident interviews, observation, and review of the facility policy, the facility failed to ensure Resident #3, #29, #45, #49, #53, #63, #41, #7, #44, #1, #2, and #5 were provided assistance with activities of daily living for showering. This affected 12 residents (#3, #29, #45, #49, #53, #63, #41, #7, #44, #1, #2, and #5) of 22 resident records reviewed for activities of daily living. The facility identified 44 residents (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #16, #18, #19, #20, #21, #22, #23, #25, #27, #29, #30, #32, #36, #39, #40, #41, #42, #43, #44, #45, #47, #49, #50, #51, #52, #53, #54, #55, #61, #62, and #63) who required staff assistance for showers and bathing. The facility census was 53. Findings include: 1. Review of the medical record for Resident #3 revealed an original admission date of 04/15/23. Diagnoses included but were not limited to end stage renal disease with dependence upon renal dialysis, type two diabetes mellitus with retinopathy, morbid obesity, hemiplegia and hemiparesis. Review of the 05/27/25 quarterly Minimum Data Set (MDS) 3.0 assessment for Resident #3 revealed intact cognition and Resident #3 was dependent on staff for bathing. Review of the facility resident shower book revealed Resident #3's room number was not listed on any of the shower schedules for any day or any of the three shifts. No evidence was found for any shower sheets for Resident #3 from 06/01/25 to 08/26/25. Review of the medical record shower/bath task for Resident #3 for the past thirty days from 07/28/25 to 08/28/25 revealed one recorded shower on 07/28/25. An interview on 08/28/25 at 7:55 A.M. with Resident #3 revealed he was supposed to get showers on Tuesdays and Thursdays but did not always get his showers twice a week. Resident #3 stated he did not get a shower yesterday and was hoping to get a shower today. 2. Review of the medical record for Resident #29 revealed an admission date of 05/04/21. Diagnoses included but were not limited to unspecified fracture of left lower leg, type two diabetes mellitus with proliferative diabetic retinopathy with bilateral macular edema, stage two chronic kidney disease (CKD), vascular dementia, and hemiplegia and hemiparesis. Review of the 06/22/25 quarterly MDS 3.0 assessment for Resident #29 revealed severe cognitive impairment. Resident #29 was noted to require maximum assistance with bathing. Review of Resident #29's care plan, last reviewed 07/08/25, revealed an activity of daily living (ADLs) performance deficit related to diagnosis of hemiplegia and hemiparesis. Resident #29 was noted to require maximum assistance with bathing. Review of the shower schedule for Resident #29 revealed showers were to be given on Wednesday and Saturday on second shift. Review of the shower sheets for Resident #29 from 06/01/25 to 08/26/25 revealed a shower sheet for 06/04/25, 06/21/25, 07/09/25, and 07/22/25. No additional sheets were found in the facility shower sheet book. Review of the electronic medical record (EMR) shower/bath task tab for Resident #29 revealed for the past 30 days between 07/28/25 to 08/28/25 a bed bath on 07/31/25 and on (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	08/14/25. No additional bathing was recorded under the task. 3. Review of the medical record for Resident #45 revealed an admission date of 11/23/17. Diagnoses included but were not limited to chronic systolic (congestive) heart failure, chronic obstructive pulmonary disease (COPD), vascular dementia and schizophrenia. Review of the 06/11/25 quarterly MDS 3.0 assessment for Resident #45 revealed intact cognition and set up required for bathing. Review of the care plan last reviewed on 07/08/25 for Resident #45 revealed an ADL self-care deficit related to severe vascular dementia and impaired balance. Resident #45 was noted to require set up for bathing. Review of the shower schedule for Resident #45 revealed showers were to be completed on Wednesdays and Saturdays on second shift. Review of the facility shower book revealed no shower sheets for Resident #45. Review of the EMR shower/bath task tab for Resident #45 revealed no recorded showers for the past 30 days between 07/28/25 to 08/28/25. An observation on 08/28/25 at 8:11 A.M. of Resident #45 revealed his hair was heavily oily and he presented as unkempt as if he had not had a shower in some time. Resident #45 was alert, but did not participate in an interview. 4. Review of the medical record for Resident #49 revealed an admission date of 12/12/23. Diagnoses included but were not limited to malignant neoplasm of lower lobe of right bronchus, chronic obstructive pulmonary disease (COPD), moderate protein-calorie malnutrition and anorexia. Review of the 08/09/25 annual MDS 3.0 assessment for Resident #49 revealed intact cognition and dependence on staff for bathing. Review of the care plan for Resident #49, date initiated 03/01/23, revealed a self-care performance deficit related to impaired cognitive function and COPD. Resident #49 was noted to be dependent upon staff for bathing. Review of the shower book revealed Resident #49 was scheduled to receive showers on Mondays and Thursdays during the second shift. Review of the shower sheets for Resident #49 from 06/01/25 to 08/26/25 revealed a shower sheet for 06/02/25, 06/04/25, 06/09/25, 06/12/25, 06/16/25, 07/31/25, 08/11/25, and a refusal on 08/25/25. No additional shower sheets were found. Review of the EMR shower/bath task tab for Resident #49 revealed no recorded bathing for the past 30 days from 07/28/25 to 08/28/25. An interview on 08/28/25 at 9:32 A.M. with Resident #49 revealed he would give himself a bath. When asked if the staff assisted him with showers, Resident #49 stated he was not sure. 5. Review of the medical record for Resident #53 revealed an admission date of 09/08/23. Diagnoses included but were not limited to hemiplegia and hemiparesis affecting left non-dominant side, and type two diabetes mellitus. Review of the 08/15/25 annual MDS 3.0 assessment for Resident #53 revealed intact cognition and moderate assistance required for bathing. Review of the care plan for Resident #53, date initiated 09/14/23, revealed ADL self-care deficits which required moderate assistance from staff for bathing. Review of the facility shower schedule revealed Resident #53 was scheduled to be bathed on Tuesdays and Fridays. Review of the shower sheets for Resident #53 from 06/01/25 to 08/26/25 revealed shower sheets for 06/10/25, 06/17/25, 06/24/25, 07/22/25, 07/29/25. No additional shower sheets for Resident #53 were found in the shower book. Review of the EMR shower/bath task tab for Resident #53 revealed a bed bath on 08/01/25 and a bath on 08/24/25. No additional bathing was recorded under the task section for Resident #53. An interview on 08/28/25 at 7:52 A.M. with Resident #53 revealed Resident #53 stated they were not getting showers twice a week. Resident #53 stated maybe once a week they would get a shower but definitely not twice a week and they would like a shower twice a week. 6. Review of the medical record for Resident #63 revealed and admission date of 07/28/25. Diagnoses included but were not limited to displaced bimalleolar fracture of right lower leg, COPD, malignant neoplasm of unspecified site of female breast, and stage three CKD. Review of the 08/04/25 (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admission MDS 3.0 assessment for Resident #63 revealed intact cognition and maximum assistance required for bathing. Review of the care plan for Resident #63, last reviewed on 08/11/25, revealed a self-care deficit related to right leg fracture, COPD and CKD and was dependent upon staff for bathing. Review of the facility shower schedule revealed Resident #63 was scheduled for showers on Tuesdays and Friday on third shift. Review of the facility shower book from 07/28/25 to 08/26/25 revealed no recorded shower sheets. Review of the EMR shower/bath task tab for Resident #63 revealed a shower on 07/29/25, 07/31/25, 08/05/25, and 08/21/25 for the past 30 days from 07/28/25 to 08/28/25. An interview on 08/28/25 at 9:51 A.M. with Licensed Practical Nurse (LPN) #607 revealed LPN #607 stated they thought Resident #63 was independent for showering. 7. Review of the medical record revealed Resident #41 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease , human immunodeficiency virus (HIV) hemiplegia and hemiparesis affected left side and generalized muscle weakness. Review of Resident #41's MDS 3.0 assessment, dated 06/24/25, revealed the resident was substantial/maximal assistance for showering bathing. Resident #41 had a Brief Mental Status of 14, revealing he was cognitively intact. Review of the care plan dated 06/18/25 revealed Resident #41 had an ADL self-care performance deficit related to diagnoses of hemiplegia/hemiparesis, congestive heart failure, schizophrenia, muscle wasting and tremors. Interventions specific to bathing/showering revealed to check nail length and trim and clean on bath day and as necessary. Bathing assistance with one to two staff members. Provide sponge bath when a full bath or shower cannot be tolerated. Review of the shower schedule revealed Resident #41 should have had showers on Wednesday and Saturdays during the first shift during the week. Review of the shower book for July and August 2025, revealed Resident #41 had no showers during the Months of July and August 2025. Resident #41 was offered a shower on 07/09/25 and refused. Review of the EMR task tab for bath/shower from 08/03/25 to 09/03/25, revealed the resident had a bed bath on 08/24/25; no other showers or refusals given for the last 30 Days for Resident #41, were documented in the tasks. An interview on 09/02/2025 at 12:01P.M. with Resident #41 confirmed he had not been receiving the showers as scheduled. 8. Resident #7 was admitted to the facility on [DATE] with diagnoses including human immunodeficiency virus (HIV), generalized muscle weakness, morbid obesity, and need for assistance with personal care. Review of Resident #7's MDS 3.0 assessment dated [DATE] revealed the resident was dependent on staff for showering bathing. Resident #7 was severely cognitively impaired and could not answer the Brief Interview for Mental Status. Review of the plan of care revised 06/19/25, revealed Resident #7 had ADL self-care performance deficit and was at risk for skin breakdown due to decreased mobility, desensitization of skin, incontinence, impaired cognition and communication, pain management needs, risk of medication side effects, and diagnoses of hemiplegia. Interventions included skin assessments to be done weekly and as needed. Interventions specific to bathing/showering revealed to check nail length and trim and clean on bath day and as necessary. Provide sponge bath when a full bath or shower cannot be tolerated. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the shower schedule book revealed Resident #7's room did not have shower days scheduled. Review of the facility shower book for July and August 2025, revealed Resident #7 had no showers given or offered for all of July or August 2025. Review of the EMR task tab for shower/bath revealed Resident #7 had no other showers or bed baths documented for the last 30 Days between 08/03/25 to 09/03/25. 9. Review of the medical record for Resident #44 revealed an admission date of 04/27/07 with diagnoses including hemiplegia and hemiparesis affecting the right dominant side, COPD, morbid obesity, major depressive disorder, peripheral vascular disease, and essential hypertension. Review of Resident #44's quarterly MDS 3.0 assessment dated [DATE] revealed the resident was dependent on staff assistance for showering bathing. Resident #44 had a Brief Mental Status was 14, which revealed the resident was cognitively intact. Review of the plan of care revised 07/09/25 revealed Resident #44 had an ADL performance deficit, was at risk for skin breakdown due to decreased mobility, incontinence, desensitization of skin, pain management needs, risk of medication side effects, and diagnoses of cerebral vascular accident. Interventions included: report changes in ADL abilities to the nurse and the physician as needed. The resident needs staff assistance with ADL including dressing, grooming, personal hygiene, and oral care. Staff to monitor signs and symptoms of skin breakdown and notify appropriate staff, and skin assessments to be done weekly and as needed. Interventions specific to bathing/showering revealed to check nail length and trim and clean on bath day and as necessary. Provide sponge bath when a full bath or shower cannot be tolerated. Review of the shower schedule revealed the Resident #44 should have had showers on Mondays and Thursdays during the first shift during the week. Review of the shower book for July and August 2025, revealed Resident #44 had one shower offered on 07/31/25. There were no other showers/bed baths offered, refused, or given. Review of the EMR shower/bath task tab revealed Resident #44 had no showers/bed baths or refusals given for the last 30 days from 08/03/25 to 09/03/25. 10. Record review for Resident #1 revealed an admission date of 03/25/25. Diagnoses included altered mental status, acute kidney failure, unspecified sequelae of cerebral infarction and need for assistance with personal care. Record review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #1 was severely cognitively impaired. He did not have any functional limitation in range of motion. There was no impairment for upper or lower extremities on either side. He used a wheelchair. He required partial to moderate assistance for shower/bathing and supervision or touching assistance for personal hygiene. Review of the care plan dated 05/19/25 revealed Resident #1 had an ADL self-care performance deficit related to diagnoses of above knee amputation, history of falls, hypertension, orthostatic hypotension, pneumonia, cardiovascular accident (CVA), hyperlipidemia and insomnia. Interventions specific to bathing/showering revealed to check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Provide sponge bath when a full bath or shower cannot (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be tolerated. Review of the shower schedule for Resident #1 revealed shower days were every Monday and Thursday. Record review of the shower sheet book revealed Resident #1 was showered/bathed 06/09/25, 06/12/25, 06/16/25, 06/19/25, 07/07/25, 07/10/25, 07/22/25 and 07/31/25. Review of the documentation for Resident #1 in the EMR shower/bath task tab for the last 30 days between 08/03/25 and 09/03/25 revealed a bed bath on 08/24 and a refusal on 09/01. 11. Review of the medical record for Resident #2 revealed an admission date of 01/14/25 with diagnoses including hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, diabetes mellitus type two, need for assistance with personal care, age related cataract bilaterally, hypertensive retinopathy bilaterally and dementia. Record review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #2 was severely cognitively impaired. He had functional limitations in range of motion impairment on both sides. He was dependent on staff for all ADLs. Review of the care plan dated 06/27/25 revealed Resident #2 had an ADL self-care performance deficit related to dementia, cardiovascular accident with right side hemiplegia. He had limited mobility and dysphagia with need for tube feeding due to eating nothing by mouth. Interventions specific to bathing/showering were to check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Provide sponge bath when a full bath or shower cannot be tolerated. The resident was totally dependent on staff to provide bath/shower as necessary. Review of the shower schedule for Resident #2 revealed his shower days were Tuesday and Friday. Review of shower sheets in the shower book revealed Resident #2 was bathed 06/06/25, 06/10/25 and 06/24/25. Review of the shower/bath task tab in the EMR for the last 30 days between 08/03/25 and 09/03/25 revealed a single bed bath on 08/06/24. 12. Review of the medical record for Resident #5 revealed an admission date of 08/30/23. Diagnoses included quadriplegia C5-C7 incomplete, personal history of malignant of neoplasm of prostate, pressure ulcer of left buttock stage three and need for assistance with personal care. Record review of the annual MDS 3.0 assessment dated [DATE] revealed Resident #5 had intact cognition. He had functional limitations in range of motion (ROM) impairment on both sides of the upper and lower extremity. He used a wheelchair. He was independent for eating. He required substantial/maximal assistance from staff for upper body dressing and was dependent on staff for all other ADL's. Review of the care plan dated 07/11/25 revealed Resident #5 had ADL self-care performance deficits related to C6 spinal cord injury with incomplete quadriplegia. Interventions, specifically for bathing/showering revealed checking nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Provide sponge bath when a full bath or shower cannot be tolerated. Review of the shower schedule for Resident #5 revealed shower days were every Wednesday and (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Saturday. Review of the shower sheet book for Resident #5 revealed showers on 05/07/25, 05/10/25, 05/14/25, 06/21/25 and 07/08/25. There were no shower sheets for August 2025. Review of the EMR under the shower/bath task tab revealed Resident #05 was given a bed bath on 08/24/25 during the last 30 days from 08/03/25 to 09/03/25. An interview with Licensed Practical Nurse (LPN) #510 on 08/26/25 at 10:25 A.M. confirmed there was a shower book kept on the second floor of the facility for residents who lived on both the first and second floor. If a resident received a shower, a shower sheet was filled out and kept in the shower book. An interview on 08/28/25 at 8:00 A.M. with Certified Nursing Assistant (CNA) #541 revealed the shower book should have a shower schedule for each resident. After completing a shower, staff would fill out a shower sheet and complete the shower task in the EMR under the shower/bath tab. The shower sheet was given to the nurse. If the CNA noticed anything abnormal with the resident during the shower, the nurse would be notified to observe the resident. An interview with CNA #563 on 08/28/25 at 8:18 A.M. revealed a shower aide was assigned to showers and worked Monday through Friday for eight hours. CNA #563 stated she worked some weekends and picked up as an aide too. CNA #563 stated the shower schedule was in the shower book. CNA #563 stated she filled out a refusal form if a shower was refused by the resident and filled out a shower sheet every time she gave a shower. CNA #563 stated she provided showers for all the residents on the second floor which consisted of four halls so she could have 12 showers to do in one shift. CNA #563 stated she had been pulled to go out on appointments with residents during the month of August and had not been able to complete her showers. In her absence, the aides were supposed to complete their resident showers if she was not there. Sometimes they are short staffed and have three aides instead of five so she gets pulled to be an aide rather than the shower aide. CNA #563 stated the aides were instructed that when there was no assigned shower aide, they are all responsible to complete their resident's shower. An interview on 09/03/25 at 11:00 A.M. with a follow up interview at 1:30 P.M. with DON #581 confirmed she had provided the complete book of shower sheets and was unable to provide additional evidence of showers provided to Resident #3, #29, #45, #49, #53, #63, #41, #7, #44, #1, #2, and #5. DON #581 verified the information in the shower book and in the EMR under the task tab revealed what was charted was what was completed. Review of the facility policy, Shower/Tub Bath, dated 10/2010, revealed the purpose of this procedure was to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. The following information should be recorded on the resident's Activity of Daily Living (ADL) record and/or in the resident's medical record: date and time the shower/tub was performed, name and title of the individual who assisted the resident with the shower/tub bath, all assessment data obtained during the shower/tub bath, how the resident tolerated the shower/tub bath, if the resident refused, what intervention was taken and the signature with title of the person recording the data. This deficiency represents noncompliance investigated under Complaint Number 1381901.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, record review, and facility assessment review, the facility failed to maintain sufficient levels of competent staff to ensure residents received the care needed to maintain the highest quality of life. This affected two residents (#58 and #74) and had the potential to affect six additional residents (#22, #26, #31, #35, #46, and #61) who resided on the first floor unit of the facility. The facility census was 53. Findings include: 1. Review of the closed medical record revealed Resident #74 was admitted to the facility on [DATE] with diagnoses including diabetes, chronic obstructive pulmonary disease (COPD), schizophrenia, depression, dependence on supplemental oxygen, heart disease, and a history of a stroke without residual effects from the stroke. Review of the physician's orders for Resident #74 revealed the following: An order dated [DATE] for one puff of a Ventolin inhaler every six hours as needed for asthma, and Ipratropium-Albuterol Inhalation Solution 0.5-2.5 milligrams (mg) per 3 milliliters to be inhaled every six hours as needed for wheezing. An advance directive order dated [DATE] for a Full Code (attempt all life-saving treatment) if his heart were to stop beating. An order dated [DATE] for oxygen to be administered continuously at four liters per minute via nasal cannula. An order written [DATE] to apply Bilevel Positive Airway Pressure (BiPAP) (a noninvasive ventilation system to administer supplemental oxygen) 45 minutes intermittently as often as possible throughout the day, every three hours for low oxygen levels. Review of the Medicare five-day comprehensive Minimum Data Set (MDS) 3.0 assessment for Resident #74 dated [DATE] revealed the resident was severely cognitively impaired, became short of breath when lying flat, and received oxygen as well as non-invasive ventilation. Review of the care plan related to Advance Directives for Resident #74, last revised on [DATE] revealed to implement full code measures per the resident's request. Review of a nursing progress note for Resident #74 dated [DATE] at 4:00 A.M. revealed LPN #532 documented at the start of her shift the resident was alert and oriented. At approximately 12:30 A.M., Resident #74 was lying flat. LPN #532 elevated the resident's head of the bed and checked his oxygen level. The resident's oxygen level was 71% (abnormal low). LPN #532 had Resident #74 use his as needed Ventolin and Ipratropium aerosol for shortness of breath. Upon completion of the breathing treatment, LPN #532 re-checked the resident's oxygen level, and it had increased to 85% (which remained below normal range). The note included LPN #532 applied the resident's BiPAP around 1:00 A.M. then re-checked his oxygen level after using it for a short while, and his oxygen level increased to 89% (remained below normal range). There was no evidence the physician was notified or evidence of adequate intervention to address this change in the resident's condition. Continued review of the nursing progress note authored by LPN #532 revealed at 2:10 A.M., LPN #532 went to check on Resident #74 and was met in the hallway by Resident #74's roommate who informed the nurse that Resident #74 was on the floor. The progress note revealed LPN #532 immediately began CPR with CNA #610 assisting with the code. The CNA re-applied Resident #74's oxygen. The note included at 2:38 A.M., 911 (EMS) was called to transport the resident to the hospital. CPR continued until EMS arrived and took over care. LPN #532 notified the Director of Nursing (DON), the Assistant Director of Nursing (ADON) the Medical Director (MD), and the resident's next of kin regarding what happened and his transport to the local emergency room (ER). LPN #532 documented on [DATE] at 4:28 A.M. that she contacted the ER and was informed Resident #74 had passed away. Review of the EMS Run Report, dated [DATE], revealed EMS received a call from the facility at 2:44 A.M. and arrived at the facility at 2:57 A.M. Resident #74 was found by EMS with CPR being performed on the floor by facility staff. After EMS arrived, they confirmed asystole (no pulse) on a monitor, they took over CPR and transported Resident #74 to the local hospital emergency room where he was pronounced dead on arrival at 3:33 A.M. An interview with LPN #532 on [DATE] at 4:09 P.M. revealed she always worked the night shift from 11:00 P.M. to (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7:00 A.M. and she was typically assigned to work on the second floor. She verified she was the nurse assigned to care for Resident #74 on ([DATE]) the night the resident coded and passed away. LPN #532 stated on this night she had the resident sit up on the edge of his bed, she gave him his inhaler and then breathing treatment for shortness of breath. LPN #532 stated she felt Resident #74 was feeling better after his breathing treatment. LPN #532 said about an hour later she went to see how the resident was feeling and was informed by Resident #74's roommate that the resident was on the floor. LPN #532 said she yelled for help immediately and CNA #610 said she was CPR certified and offered to help. LPN #532 said she did not check to see if Resident #74 had a pulse, she just started CPR. LPN #532 stated that LPN #633 called 911 but it took LPN #633 30 minutes before she called 911 for emergency services. LPN #532 stated she did not know why it took LPN #633 so long to call 911. LPN #532 stated she later contacted the hospital and was told Resident #74 had expired. LPN #532 stated she was orienting LPN #633 that shift, and LPN #633 brought the crash cart to Resident #74's room. During the interview LPN #532 stated LPN #633 and CNA #610 no longer worked at the facility but did not provide any additional information related to why. An interview on [DATE] at 11:35 A.M. with Medical Director (MD) #614 revealed EMS should be called immediately for any resident who goes into cardiac arrest. Medical Director #614 also stated the nurse should check for a pulse before starting CPR. A telephone interview with LPN #633 on [DATE] at 6:49 P.M. revealed she had only worked for the facility for a few weeks. During the interview, she stated she remembered the night of [DATE] when Resident #74 coded as stated it was very frightening. LPN #532 had yelled for help after the LPN had found the resident on the floor. CNA #610 was assisting LPN #532, so LPN #633 stated she went back to the nurses' station to try and find information about the resident so she could call for help. LPN #633 said she tried to call 911 but was unable to figure out how to use the facility phone. LPN #633 said she finally used her personal phone to call 911. LPN #633 said she did not know the address of the facility to provide to EMS. LPN #633 then said she printed off a copy of the face sheet for EMS and then had to go downstairs to get the copy. She stated she did not know the code to allow the squad to enter the facility. LPN #633 stated after the incident she changed her status to as needed and had not worked at the facility since. 2. Review of the record revealed Resident #58 was admitted to the facility on [DATE] with diagnoses including pneumonia, chronic obstructive pulmonary disease (COPD), diabetes, high blood pressure, congestive heart failure (CHF), major depressive disorder, and altered mental status. Review of the physician's orders dated [DATE] for Resident #58 revealed the following orders: skilled level of care and skilled assessment and monitoring every shift, full code status, head of the bed should be elevated to 45 degrees or higher to ease her breathing, use of an Albuterol inhaler one puff every six hours as needed for shortness of breath, Ipratropium Bromide 0.02% solution aerosol four times a day for asthma, and Albuterol-Budesonide aerosol 90-80 micrograms every six hours as needed for wheezing. Review of the comprehensive Minimum Data Set (MDS) 3.0 admission assessment, dated [DATE], revealed Resident #58 was severely cognitively impaired, required moderate to maximum assistance for all activities of daily living, had shortness of breath when lying flat, and was a smoker. The resident received speech therapy, occupational therapy, and physical therapy. Review of Resident #58's care plan, date initiated [DATE], revealed on [DATE] the care plan was updated to include that the resident was known to refuse her oral inhaler and the physician should be notified on refusals. There was no code status listed on the care plan. Review of the progress notes for Resident #58 dated [DATE] through [DATE] revealed Resident #58 had no complaints of respiratory distress or other complaints. There were no progress note entries made by nursing on [DATE]. Review of a progress note dated [DATE] at 3:44 A.M. authored by RN #511 revealed Resident #58 had activated her call light. RN #511 responded to the call light and the resident complained of being short of breath. RN #511 gave the resident her Albuterol inhaler and elevated the head of the resident's bed. The inhaler and elevating the head of the resident's bed was ineffective. RN #511 then initiated a breathing treatment and left the resident sitting on the edge of her bed. A few minutes later Resident #58 (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	activated her call light again and told the nurse she needed oxygen. RN #511 left the room to get an oxygen concentrator. When RN #511 returned to the room, Resident #58 was laying across her bed and was unresponsive. RN #511 went up to the second floor to get another nurse (LPN #532). The nurses immediately started CPR while an unidentified CNA called 911 at 2:51 A.M. The residents heart rate was 188 beats per minute and oxygen was 57% via nasal cannula. EMS arrived at 3:10 A.M. CPR was performed. Resident #58 was taken to the ER and the physician, DON and emergency contact were notified. Interview with the Director of Nursing (DON) on [DATE] at 11:25 A.M. revealed she had worked for the facility for several years as a night shift supervisor but had only been the DON for a few weeks. She stated the nurse assigned to the first floor also had residents assigned to her on the second floor and the facility recently changed staffing to always have a CNA on the first floor for staffing. If an emergency were to occur, the CNA would call for help. The CNA could overhead page for help but most likely they would run to the second floor for help. An observation conducted on [DATE] at 2:40 P.M. revealed no staff were present on the first-floor nursing unit and no staff were observed in any of the resident occupied rooms on the unit. Interview with RN #606, RN #517, and LPN #521 on [DATE] from 2:45 P.M. revealed all three nurses had worked for the facility for a month or less. None of them were aware of the facility having a code team consisting of one nurse and two CNAs. They all agreed they had not seen or heard of a Code Blue documentation sheet. All three confirmed there had been no in-services for mock codes and they were not trained on it during orientation. An interview with CNA #579 on [DATE] at 3:00 P.M. revealed she was assigned to care for the residents on the first floor but she came up to the second floor. When asked why she was on the second floor instead of her assignment on the first floor she stated I don't remember why she had come up to the second floor. CNA #579 confirmed she was not CPR certified and was unaware the facility had a CPR team. CNA #579 then went to the elevator and returned to the first floor. CNA #579 verified the first floor had been left without a staff member while she was on the second floor. Interviews with CNA #563 and CNA #523 on [DATE] at 3:05 P.M. revealed neither one was aware that there was a CPR team on each shift nor who was to be assigned to it. Interview with Former DON (FDON) #604 on [DATE] at 3:10 P.M. revealed the facility had not yet come up with a plan regarding how the first-floor staff were to obtain help since the incident with Resident #58 had just occurred and they had not had time to determine how to fix the problem. FDON #604 stated they always had the capability of overhead paging and everyone knew how to do that. Interview with Registered Nurse (RN) #511 on [DATE] at 4:30 P.M. revealed she was assigned to the first floor on [DATE]. She preferred to be the one assigned to the first floor as opposed to an aide as she felt a nurse should be the first line of defense for the building. RN #511 confirmed she was also assigned residents on the second floor as well. She stated Resident #58 activated her call light and RN #511 went to her room to see what the resident needed. The resident said she was short of breath. RN #511 elevated the head of the resident's bed then went to the medication cart and brought the resident's Albuterol inhaler to use. The resident inhaled two puffs. Before RN #511 was able to leave the room, Resident #58 said the inhaler was not helping and requested an aerosol treatment. RN #511 obtained the resident's Albuterol-Budesonide aerosol 90-80 micrograms and started the aerosol treatment. Resident #58 then requested oxygen be obtained. RN #511 left the first floor, went up to the second floor and retrieved an oxygen concentrator and oxygen tubing which she then took back down to the resident's room. RN #511 had left Resident #58 sitting up in bed when she went to get the oxygen and when she returned to the room, RN #511 found the resident lying on the bed. RN #511 said she nudged the resident, but nothing happened, and the resident did not respond. RN #511 said she was the only person working on the floor, so she had to go to the elevator, push the button for the elevator, take the elevator to the second floor then yelled for help. LPN #532 and an unidentified aide came to RN #511's assistance and they returned to the first floor. When asked if there was any other way to obtain help, RN #511 said no, she could not overhead page and they had requested walkie talkies in order to reach assistance from the second floor, but nothing had come from it. RN #511 also confirmed the facility (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	did not have an AED to use on a resident who went into cardiac arrest. RN #511 said she and LPN #532 took the crash cart to Resident #58's room and the unidentified aide called 911. Upon entering Resident #58's room, RN #511 and LPN #532 immediately began CPR on the resident in her bed, and they did not place a backboard under the resident. RN #511 said she did not check a pulse, and the facility did not have an AED to determine if a resident needed shocked to restart the heart. RN #511 said she and LPN #532 continued CPR until EMS arrived and transferred the resident to the local emergency room (ER). RN #511 said the evening shift nurse, LPN #544, did not report anything unusual about Resident #58 at the earlier change of shift. Interview with LPN #532 on [DATE] at 4:09 P.M. revealed she was typically assigned to work on the second floor. LPN #532 confirmed she remembered when Resident #58 coded. LPN #532 said the resident was in respiratory distress and RN #511 gave her the inhaler, then an aerosol treatment, then retrieved the oxygen the resident wanted from the second floor. LPN #532 said the next thing she knew RN #511 returned to the second floor calling for help. LPN #532 said she and an unidentified aide went back to the first floor with RN #511. RN #511 and LPN #532 grabbed the crash cart and went to the resident's room while the aide called 911. LPN #532 said she thought Resident #58 had a pulse still as the pulse oximeter was picking up an oxygenation level. She stated RN #511 did not check for a pulse before starting CPR. LPN #532 said CPR continued until EMS arrived and took over. They transported Resident #58 to the ER where she was pronounced deceased. Interview with LPN #510 on [DATE] at 11:15 A.M. revealed she did remember Resident #58. The resident was on the first floor in the new unit that opened sometime in [DATE]. LPN #510 said the resident was alert, independently mobile, and knew what she wanted. Resident #58 never complained about being short of breath, not feeling well, or chest pain. LPN #510 said they were all shocked when Resident #58 died. LPN #510 said staffing for the first floor was that the nurse covered the residents on the first floor as well as two units on the second floor. On night shift, a CNA was assigned to the first floor and could not leave the unit without another staff member replacing the aide. Review of the Facility Assessment, dated [DATE], revealed staff training, staff education and competencies training program includes an orientation process and ongoing training for all new and existing including managers, nursing, and other direct care staff, individuals providing services under contractual arrangement, and volunteers consistent with their expected roles. The facility completes an emotional need assessment and develop a curriculum and training plan based on staff need and resident characteristics. The content at a minimum includes effective communication; resident rights and facility responsibilities; abuse, neglect, and exploitation; infection control; culture change/person-centered care; dementia management and abuse prevention; special needs of residents; caring for residents who are cognitively impaired; identification of resident changes in condition; cultural competency/trauma informed care; QAPI (Quality Assurance and Performance Improvement); compliance and ethics; emergency preparedness; and workplace hazards. The facility conducts a formal evaluation of the training program. The purpose statement noted the purpose statement of this assessment is to determine what resources are necessary to care for our residents competently during both day-to-day operations (including nights and weekends) and emergencies. Facility resources included all personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care. This deficiency represents noncompliance investigated under Complaint Number 1381901.		

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and review of the facility policy, the facility failed to ensure medications in the medication cart were labeled and stored in proper containers. This had the potential to affect 30 Residents (#2, #6, #8, #16, #18, #19, #20, #21, #22, #23, #25, #26, #30, #31, #33, #35, #36, #37, #39, #42, #43, #44, #45, #46, #47, #49, #50, #52, #60, and #61) who received medications from the medication carts reviewed. The facility census was 53. Findings include: Observation on 08/20/25 at 3:15 P.M. of the medication cart on the sycamore hall revealed there were 15 loose pills of various shapes and colors in the bottom of the medication cart. Interview on 08/20/25 at 3:15 P.M. with Registered Nurse (RN) #606 and Licensed Practical Nurse (LPN) #559 confirmed 15 loose pills of various shapes and colors in the bottom of the medication cart for the sycamore hall. RN #606 & LPN #559 confirmed they were not able to identify the 15 pills nor to whom the 15 pills were prescribed. Observation on 08/20/25 at 3:21 P.M. of the crystal [NAME] hall medication cart revealed there were 20 loose pills of various shapes and colors in the bottom of the medication cart. Interview on 08/20/25 at 3:21 P.M. with LPN #607 confirmed 20 loose pills of various shapes and colors in the bottom the nurse of the crystal [NAME] hall medication cart. LPN #607 confirmed she was not able to identify the 20 pills nor to whom the 20 pills were prescribed. Observation on 08/20/25 at 3:47 P.M. of the carousel hall revealed there were 5 loose pills of various shapes and colors in the bottom of the medication cart. Interview on 08/20/25 at 3:47 P.M. with LPN #578 confirmed five loose pills of various shapes and colors in the bottom of the medication cart for the carousel hall cart confirmed she was not able to identify the five pills nor to whom the five pills were prescribed. Review of the facility policy titled, Storage of Medications, dated 04/07, revealed drugs and biologicals should be stored in the packaging in which they are received and the nursing staff is responsible for maintaining medication storage. This deficiency represents non-compliance investigated under Complaint Number 2578214.		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interviews, record review and review of facility policy, the facility failed to ensure the policy pertaining to use and storage of food in resident room refrigerators was implemented and addressed temperature monitoring for food safety. This affected four residents (Residents #4, # 9, #43, and #44) of four residents reviewed for personal food storage. The facility identified seven residents (Residents #4, #9, #16, #36, #43, #44 and #47) as storing food in room refrigerators. The facility census was 53. Findings include: 1. Review of the medical record for Resident #44 revealed an admission date of 08/20/09. Diagnoses included hemiplegia and hemiparesis, morbid obesity and polyneuropathy. Review of the 07/15/25 quarterly Minimum Data Set (MDS) 3.0 assessment for Resident #44 revealed he was cognitively intact, received a no added salt (NAS) diet, and required set up for meals. An observation on 08/21/25 at 1:45 P.M. with Regional Dietary Manager (RDM) #598 revealed Resident #44's refrigerator had a plastic sleeve on the outside of it with an undated temperature monitoring log with the first eighteen days completed. The temperature monitoring logs behind it were dated from January, February and March 2025. No additional temperature logs were found. An interview on 08/21/25 at 1:40 P.M. with the Administrator revealed the maintenance department was to monitor the resident room refrigerators and there were three residents with refrigerators in their rooms. The Administrator did not identify the three residents. An interview on 08/21/25 at 1:40 P.M. with Licensed Practical Nurse (LPN) #521 revealed there were four residents (Residents #4, #9, #43, and #44) on the second floor with refrigerators in their rooms. An interview on 08/21/25 at 2:44 P.M. with Maintenance #538 revealed Certified Nurse Aides (CNAs) were responsible to monitor resident refrigerator temperatures. An interview on 08/21/25 at 2:47 P.M. with CNA #523 revealed CNA #523 stated it was the nurses' responsibility to check the resident refrigerator temperatures. An interview on 08/21/25 at 2:51 P.M. with LPN #521 revealed she was never told to check resident room refrigerators or monitor refrigerator temperatures. LPN #521 stated upon further checking there were seven residents with resident room refrigerators (Residents #4, #9, #16, #36, #43, #44, and #47). An interview on 08/28/25 at 10:02 A.M. with Resident #44 revealed "sometimes" the staff checked his refrigerator and he did not think it was checked weekly. 2. Review of the medical record for Resident #43 revealed an admission date of 08/01/20. Diagnoses included chronic obstructive pulmonary disease, dysphagia, hemiplegia and hemiparesis. Review of the 07/22/25 five-day admission MDS 3.0 assessment revealed intact cognition. Resident #43 was noted to receive a regular diet, require set up for meals and was dependent upon staff for activities of daily living (ADL). An observation on 08/21/25 at 1:47 P.M. with RDM #598 of Resident #43's room refrigerator revealed no temperature monitoring logs in or around the refrigerator. An interview on 08/28/25 at 10:04 A.M. with Resident #43 revealed she was unaware if anyone was monitoring her room refrigerator and had never observed someone checking the refrigerator. (continued on next page)		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the medical record for Resident #9 revealed an admission date of 09/09/24. Diagnoses included gastroparesis, chronic obstructive pulmonary disease and type II diabetes mellitus. Review of the 06/18/25 quarterly MDS 3.0 assessment for Resident #9 revealed intact cognition. Resident #9 was noted to receive a NAS, Reduced Concentrated Sweets diet, was independent for meals and dependent on staff for ADL. An observation on 08/21/25 at 1:49 P.M. with RDM #598 of Resident #9's room refrigerator revealed no temperature monitoring logs on and around the refrigerator. Interview at the time of observation with Resident #9 revealed no one had checked his refrigerator "in a long time". An interview on 08/28/25 at 10:06 A.M. with Resident #9 revealed someone had checked his refrigerator yesterday but was unsure the last time prior to yesterday whether the temperature or the items inside were checked. 4. Review of the medical record for Resident #4 revealed an admission date of 03/20/25. Diagnoses included multiple sclerosis, morbid obesity and type two diabetes mellitus. Review of the 07/01/25 quarterly MDS 3.0 assessment for Resident #4 revealed intact cognition. Resident #4 was noted to receive a regular diet, required set-up for meals and was dependent upon staff for ADL. An observation on 08/21/25 at 1:54 P.M. with RDM #598 of Resident #4's room refrigerator revealed no temperature monitoring log on or around the refrigerator. A 12.05-ounce (oz) plastic container of pre-prepared beef stew was found and had an expiration date of 07/03/25, an eight-ounce container of parmesan cheese was found with an expiration date of 08/19/23. Interview with RDM #598 at the time of the observation verified the findings. An interview on 08/28/25 at 10:08 A.M. with Resident #4 revealed she was unsure if anyone ever checked her refrigerator or monitored temperatures and stated if they had then it was not being done consistently. Review of the facility policy titled Food Brought in for Patients and Residents, dated 11/27/17, revealed food brought to residents by family or visitors will be handled and stored in a safe and sanitary manner and may be stored in personal refrigerators in resident rooms. Food items that require refrigeration must be labeled, dated and will be held in the refrigerator for three days after the date on the label then discarded by staff. Foods considered unsafe or beyond the expiration date will be discarded by staff. The policy did not specify any procedure or instructions related to maintaining and monitoring safe food temperatures in resident room refrigerators. This deficiency represents non-compliance investigated under Complaint Number 2578214.		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on document review and interview, the facility failed to have an updated and accurate facility assessment to indicate sufficient staffing for the first floor. This had the potential to affect six residents (#22, #26, #31, #35, #46 and #61) identified by the facility as residing on the first floor. The facility census was 53. Findings include: A review of a document titled; Facility Assessment dated 02/24/25 was marked as reviewed by Licensed Nursing Home Administrator (LNHA) #628. The document stated the reason for review was change in management/new administrator. The document was reviewed by the Quality Assurance Committee on 03/22/25. The purpose of the assessment was to determine what resources are necessary to care for the residents competently during both day-to-day operations and emergencies. Under the subtitle, Facility Assessment and Staffing Needs it was stated the facility will consider specific staffing needs for each resident unit in the facility. Page 19 of the document had a subsection titled, Staffing Needs as per Resident Unit. The document stated to add additional sections and adjust as needed. The unit section under Staffing Needs as per Resident Unit was blank. A review of the undated facility floor plan revealed the facility had a capacity of 15 total resident beds on the first floor. A review of the facility census by room number dated 08/18/25 revealed a total of six residents (#22, #26, #31, #35, #46 and #61) residing on the first floor unit. On 08/26/25 at 4:45 P.M., an interview with Regional Director of Operations #599 verified the facility assessment did not address staffing by unit. On 08/27/25 at 9:00 A.M., an interview with LNHA #600 revealed he was not aware the facility assessment did not address staffing by unit. Review of the Facility Assessment, dated 02/24/25, revealed staff training, staff education and competencies training program includes an orientation process and ongoing training for all new and existing including managers, nursing, and other direct care staff, individuals providing services under contractual arrangement, and volunteers consistent with their expected roles. The facility completes an emotional need assessment and develop a curriculum and training plan based on staff need and resident characteristics. The content at a minimum includes effective communication; resident rights and facility responsibilities; abuse, neglect, and exploitation; infection control; culture change/person-centered care; dementia management and abuse prevention; special needs of residents; caring for residents who are cognitively impaired; identification of resident changes in condition; cultural competency/trauma informed care; QAPI (Quality Assurance and Performance Improvement); compliance and ethics; emergency preparedness; and workplace hazards. The facility conducts a formal evaluation of the training program. The purpose statement noted the purpose statement of this assessment is to determine what resources are necessary to care for our residents competently during both day-to-day operations (including nights and weekends) and emergencies. Facility resources included all personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview and facility policy review, the facility failed to ensure medical record documentation included weekly skin assessments as ordered and care planned for Resident #1, #3, #7, #9, #29, #44, #45, #49, #53, #63, and #69, and failed to ensure the change of condition and subsequent death of Resident #76 was documented in the medical record. This affected 12 Residents (#1, #3, #7, #9, #29, #44, #45, #49, #53, #63, #69 and #76) of 22 residents reviewed for complete resident records. The facility census was 53. Findings include: 1. Review of the medical record for Resident #3 revealed an admission date of [DATE]. Diagnoses included but were not limited to end stage renal disease with dependence upon renal dialysis, type two diabetes mellitus with retinopathy, morbid obesity, hemiplegia and hemiparesis. Review of the [DATE] physician order for Resident #3 revealed an order for a weekly skin assessment to be completed every Monday. Review of the [DATE] quarterly Minimum Data Set (MDS) 3.0 assessment for Resident #3 revealed intact cognition and Resident #3 was noted to be dependent on staff for Activities of Daily Living (ADLs). Resident #3 was also noted to be at risk for skin breakdown. Review of the care plan for Resident #3 revealed it was last updated on [DATE]. Resident #3 was noted to be at risk for skin breakdown related to decreased mobility, hemiplegia and morbid obesity. Interventions listed included a skin assessment weekly to be completed. Further review of the medical record for Resident #3 revealed skin assessments from [DATE] to [DATE] were completed on [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. There were no weekly skin assessments completed on [DATE], [DATE], [DATE], [DATE], and [DATE]. 2. Review of the medical record for Resident #29 revealed an admission date of [DATE]. Diagnoses included but were not limited to unspecified fracture of left lower leg, type two diabetes mellitus with proliferative diabetic retinopathy with bilateral macular edema, stage two chronic kidney disease, vascular dementia, and hemiplegia and hemiparesis. Review of the [DATE] physician order for Resident #29 revealed an order for a weekly skin assessment to be completed every Tuesday. Review of the [DATE] quarterly MDS 3.0 assessment for Resident #29 revealed severe cognitive impairment. Resident #29 was noted to require maximum assistance with bathing and noted to be at risk for skin breakdown. Review of Resident #29's care plan, updated [DATE], revealed an ADL performance deficit related to diagnosis of hemiplegia and hemiparesis. Resident #29 was noted to require maximum staff assistance with bathing, dressing and personal hygiene. Resident #29 was also noted to be at risk for skin breakdown with an intervention listed for a skin assessment to be completed weekly. Further review of the medical record for Resident #29 revealed from [DATE] to [DATE] only one completed skin assessment on [DATE]. There were no other weekly skin assessments completed for Resident #29. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the medical record for Resident #45 revealed an admission date of [DATE]. Diagnoses included but were not limited to chronic systolic (congestive) heart failure, chronic obstructive pulmonary disease, vascular dementia and schizophrenia. Review of the [DATE] physician order for Resident #45 revealed an order for a body audit to be completed every night shift every Tuesday for skin observation and weekly skin assessment. Review of the [DATE] quarterly MDS 3.0 assessment for Resident #45 revealed intact cognition, independent for most ADLs and required set up for bathing. Resident #45 was also noted to be at risk for skin breakdown. Review of the care plan last reviewed on [DATE] for Resident #45 revealed an ADL self-care deficit related to severe vascular dementia and impaired balance and was also at risk for skin breakdown related to decreased mobility, incontinence and impaired cognition. Interventions included completing a skin assessment weekly. Further review of the medical record for weekly skin assessments for Resident #45 revealed between [DATE] to [DATE] weekly skin assessments were not completed on [DATE], [DATE] or [DATE]. 4. Review of the medical record for Resident #49 revealed an admission date of [DATE]. Diagnoses included but were not limited to malignant neoplasm of lower lobe of right bronchus, chronic obstructive pulmonary disease (COPD), moderate protein-calorie malnutrition and anorexia. Review of the physician order dated [DATE] for Resident #49 revealed an order for a weekly skin assessment to be completed on Tuesdays. Review of the [DATE] annual MDS 3.0 assessment for Resident #49 revealed intact cognition, dependence on staff for bathing and Resident #49 was noted to be at risk for skin breakdown. Review of the care plan for Resident #49, last reviewed on [DATE], revealed a self-care performance deficit related to impaired cognitive function and COPD. Resident #49 was noted to be at risk for skin breakdown related to altered nutritional status, diagnosis of anorexia with malnutrition. Interventions included a weekly skin assessment ordered to be completed. Further review of the medical record for Resident #49 revealed no weekly skin assessments were documented as complete since [DATE]. 5. Review of the medical record for Resident #53 revealed an admission date of [DATE]. Diagnoses included but were not limited to hemiplegia and hemiparesis affecting left non-dominant side, and type two diabetes mellitus. Review of the [DATE] physician order for Resident #53 revealed an order for a weekly skin assessment to be completed every Tuesday. Review of the [DATE] annual MDS 3.0 for Resident #53 revealed intact cognition and moderate assistance required for bathing. Resident #53 was also noted to be at risk for skin breakdown. Review of the care plan for Resident #53 last reviewed on [DATE] revealed ADL self-care deficits which required moderate assistance from staff for bathing. Resident #53 was also noted to be at risk (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for skin breakdown related to decreased mobility, incontinence and flaccid left hemiplegia. Interventions listed included completing a weekly skin assessment. Further review of the medical record for Resident #53 revealed one weekly skin assessment on [DATE] from [DATE] to [DATE]. No additional skin assessments were found. 6. Review of the medical record for Resident #63 revealed and admission date of [DATE]. Diagnoses included but were not limited to displaced bimalleolar fracture of right lower leg, COPD, malignant neoplasm of unspecified site of female breast, and stage three chronic kidney disease (CKD). Review of the [DATE] physician order for Resident #63 revealed an order for weekly skin assessments to be completed in the electronic medical record every Wednesday. Review of the [DATE] admission MDS 3.0 for Resident #63 revealed intact cognition and maximum assistance required for bathing. Resident #63 was also noted to be at risk for skin breakdown. Review of the care plan for Resident #63 last reviewed on [DATE] revealed a self-care deficit related to right leg fracture, COPD and CKD and was dependent upon staff for bathing. Resident #63 was also noted to be at risk for skin breakdown due to decreased mobility and intervention listed was a weekly skin assessment to be completed. Further review of the medical record for Resident #63's weekly skin assessments from [DATE] to [DATE] revealed assessments were completed on [DATE] and [DATE]. No additional assessments were recorded in the medical record. 7. Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] with admitting diagnoses included but not limited to surgical aftercare following surgery on the digestive system, chronic obstructive pulmonary disease, human immunodeficiency virus (HIV), morbid obesity, muscle weakness, and need for assistance with personal care. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #7 had severe cognitive impairment and was dependent on staff transfers and for bathing. Review of the plan of care revised [DATE], revealed Resident #7 had ADL self-care performance deficits and was at risk for skin breakdown due to decreased mobility, desensitization of skin, incontinence, impaired cognition and communication, pain management needs, risk of medication side effects, and diagnoses of hemiplegia. Interventions included skin assessments to be done weekly and as needed. Review of the weekly skin assessments for Resident #7 for the date range of [DATE] to [DATE] revealed weekly skin assessments were completed on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. All other weekly assessments were missing for the period of [DATE] to [DATE]. 8. Review of the medical record for Resident #44 revealed an admission date of [DATE] with diagnoses including but were not limited to hemiplegia and hemiparesis affecting the right dominant side, COPD, morbid obesity, major depressive disorder, peripheral vascular disease, and essential hypertension. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #44's quarterly MDS 3.0 assessment dated [DATE] revealed Resident #44 was dependent on staff assistance for showering/bathing. Resident #44 had intact cognition. Review of the care plan revised [DATE] revealed Resident #44 had an ADL performance deficit, was at risk for skin breakdown due to decreased mobility, incontinence, desensitization of skin, pain management needs, risk of medication side effects, and diagnoses of cerebral vascular accident. Interventions included: report changes in ADL abilities to the nurse and the physician as needed; and the resident needs staff assistance with ADLs including dressing, grooming, personal hygiene, and oral care; staff to assess signs and symptoms of skin breakdown and notify appropriate staff, and skin assessments to be done weekly and as needed. Further review of the medical record revealed Resident #44 had only one skin assessment completed during the month of [DATE] on [DATE]. There were no other weekly skin assessments completed in [DATE]. Resident #44's weekly skin assessments were completed as ordered in July and [DATE]. 9. Record review of Resident #01 revealed an admission date of [DATE]. Diagnoses included altered mental status, acute kidney failure, unspecified sequelae of cerebral infarction and need for assistance with personal care. Record review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #01 was severely cognitively impaired, and did not have any functional limitation in range of motion. There was no impairment for upper or lower extremities on either side. Resident #01 used a wheelchair, required partial to moderate assistance for shower/bathing and supervision or touching assistance for personal hygiene. Review of physician orders for Resident #01 revealed an order for a weekly body audit dated [DATE] every day shift on Wednesday for skin assessment and complete a weekly skin assessment form in the electronic medical record (EMR). Further review of the medical record for Resident #01 revealed weekly skin assessments were completed as ordered on [DATE]. There were no weekly skin assessments completed in [DATE]. The next weekly skin assessment was completed on [DATE] then were completed weekly as ordered. 10. Record review for Resident #09's revealed an admission date of [DATE]. Diagnoses included unspecified dementia, chronic diastolic congestive heart failure, unsteadiness on feet and need for assistance with personal care. Review of physician orders revealed Resident #09 had an order dated [DATE] for a skin observation to be done every Tuesday, on night shift and complete a weekly skin assessment. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #09 was cognitively intact, did not have any functional limitation in range of motion for both upper and lower extremity, used a wheelchair, was independent for eating and for oral hygiene, required set up or clean up assistance and for all other ADL's Resident #09 was dependent on staff. Further record review for Resident #09 revealed weekly skin assessments were done [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]. There were no other weekly skin assessments in the medical records. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11. Review of the closed record for Resident #69 revealed an admission date of [DATE] and a discharge date of [DATE]. Diagnoses included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting the right, non-dominant side, dysphagia, unspecified dementia and need for assistance with personal care. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #69 was moderately impaired cognitively for daily decision making. He was dependent on staff for all ADL's except eating he needed set-up assistance. Resident #69 was always incontinent of both bowel and bladder. Review of the care plan for Resident #69, date initiated [DATE], revealed he was at risk for skin breakdown due to decreased mobility and incontinence. A weekly skin assessment was listed as an intervention. Further review of the medical record for Resident #69 revealed the weekly skin assessments were not completed weekly in April, May, July and [DATE] as care planned with the exception of [DATE], [DATE], [DATE] and [DATE] those assessments were signed off as completed. An interview on [DATE] at 9:51 A.M. with Licensed Practical Nurse (LPN) #607 confirmed weekly skin assessments were to be completed in the electronic medical record (EMR) under the assessment tab of the EMR. An interview on [DATE] at 1:30 P.M. with Director of Nursing (DON) #581 revealed if a resident had an order for a weekly skin assessment the nurses would indicate yes or no on the Treatment Administration Record (TAR) to indicate completion of the weekly skin assessment, however, DON #581 verified this gave no details about the condition of the residents skin, so a complete skin assessment should also be completed by the nurse in the electronic medical record (EMR). DON #581 stated the skin assessments were located under the assessment tab in the EMR for each week for each resident. DON #581 verified the weekly skin assessments had not been completed as ordered for Residents #1, #3, #7, #9, #29, #44, #45, #49, #53, #63, and #69 and she was unable to provide any evidence of weekly skin assessments being completed for these residents on the missing dates identified. Review of the [DATE] revised facility policy called; Prevention of Pressure Ulcers/Injuries revealed the facility would complete a comprehensive skin assessment upon admission and skin assessments were to be completed weekly by a licensed nurse. Review of the [DATE] revised facility policy titled Charting and Documentation revealed all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record shall facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The following information is to be documented in the resident medical record: objective observations, medications administered, treatments or services performed, changes in resident condition, events, incidents or accidents involving the resident and progress toward or changes in the care plan. 12. Review of the closed medical record for Resident #76 revealed an admission date of [DATE] and date of death of [DATE]. Diagnoses included but were not limited to urinary tract infection, unspecified severe protein-calorie malnutrition, hemiplegia and hemiparesis and encephalopathy. A change of condition assessment dated [DATE] revealed Resident #76 was having a decline in his (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	health. Review of a physician order for Resident #76 dated [DATE] revealed he was referred to hospice due to failure to thrive. Review of the significant change MDS 3.0 assessment for Resident #76 dated [DATE] revealed severe cognitive impairment. Resident #76 was receiving hospice and was dependent upon staff for activities of daily living (ADLs). Review of the physician order dated [DATE] for Resident #76 revealed an order for admission to hospice services. Review of the hospice contract dated [DATE] revealed Resident #76 started hospice services on [DATE]. Review of the nursing progress notes for Resident #76 from [DATE] to [DATE] did not reveal any progress notes indicating changes in condition, notifications of physician, family, death in facility or release of Resident #76's body to a funeral home. An interview on [DATE] at 12:15 P.M. with DON #581 confirmed when a change in condition occurred, nursing was supposed to complete a change in condition assessment in the EMR and notify the physician, family and hospice if the resident was receiving hospice. If the resident expired, hospice would be notified. Nurses would document communication and actions in the EMR as a progress note. An interview on [DATE] at 12:24 P.M. with DON #604 confirmed when a change in condition and/or death occurred the nurse should document changes in the EMR including notification to the physician, family and hospice. DON #604 confirmed Resident #76's medical record did not provide evidence of any notification of change in condition following hospice initiation on [DATE] and did not list any events leading up to death, notifications or release of Resident #76's body. Review of the [DATE] updated facility policy titled Change in a Resident's Condition or Status revealed the facility shall promptly notify the resident, his or her attending physician and representative of changes in the resident's medical condition and/or status. The nurse will record in the resident's medical record any information related to changes in the resident's medical/mental condition or status.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a catheter drainage bag was placed in a privacy bag to maintain dignity. This affected one resident (Resident #27) of three residents (Residents #4, #5 and #27) identified with urinary drainage systems. The Facility census was 53. Findings include: Review of medical records for Resident #27 revealed a date of admission of 05/07/25. Significant diagnoses included other mechanical complication of other urinary catheter, obstructive and reflux uropathy, and neuromuscular dysfunction of the bladder. Significant orders included indwelling foley catheter, change foley catheter every 28 days and as needed, empty foley catheter every shift, monitor urine for color, clarity, and odor, and consult urology for catheter change every 28 days. Review of the admission minimum data set 3.0 assessment dated [DATE] revealed Resident #27 was cognitively intact. The assessment also noted an indwelling urinary catheter. Review of the care plan dated 05/13/25 revealed Resident #27 had an indwelling urinary catheter. Interventions included position catheter bag and tubing below the level of the bladder and away from entrance room door, check tubing for kinks each shift and monitor for signs and symptoms of discomfort due to catheter. On 08/18/25 at 1:21 P.M. an observation of Resident #27 revealed him sitting in a wheelchair with the urinary catheter drainage bag noted to be hanging below the level of the bladder. The urinary catheter drainage bag was noted to not have a privacy bag in place to maintain the dignity of resident #27. The aforementioned observation was verified by Licensed Practical Nurse (LPN) #544. LPN #544 stated the drainage bag should have been placed in a privacy bag. A review of the policy titled Quality of Life-Dignity dated 08/2009, revealed each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. The policy further revealed demeaning practices in standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by helping the residents to keep urinary catheter bags covered.		

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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 interview, record review, and facility policy review the facility failed to ensure the physician was notified of resident changes in condition. This affected two residents (#13 and #85) of 22 residents reviewed for change in condition. The facility census was 53. Findings include: 1. Review of the closed medical record revealed Resident #13 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), diabetes, asthma, hemiplegia/hemiparesis after a stroke affecting the left nondominant side, congestive heart failure, atrial fibrillation, rectal cancer, and heart disease. Review of the physician's orders for Resident #13 revealed an order written on [DATE] for the resident to be a full code (perform all life saving interventions). An order was written on [DATE] to admit to hospice with a terminal diagnosis of hypertensive heart disease and chronic kidney disease with heart failure. Hospice was to be notified of all changes, falls, medication errors, equipment issues, and death. Review of Resident #13's care plan revised on [DATE] revealed the resident had chosen to be a full code. Review of the comprehensive significant change Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #13 was cognitively intact, rejected care daily, and had a life expectancy of less than six months. The assessment revealed the resident was receiving hospice services. Review of the nursing progress notes revealed Licensed Practical Nurse (LPN) #506 documented on [DATE] at 3:31 P.M. revealed Resident #13 had a coffee ground emesis. His blood pressure was low at 87/60, his pulse was high at 114 beats per minutes, and his oxygen level on room air was 93%. LPN #506 notified the unnamed hospice nurse on who informed her HRN #700 would come to the facility to assess the resident. The documentation did not indicate MD #614 was notified of the resident's status. Review of a note dated [DATE] at 8:20 P.M. (recorded as a late entry on [DATE] at 4:31 P.M.) revealed on [DATE] at 5:40 P.M., LPN #521 was notified by Hospice Registered Nurse (HRN) #700 that Resident #13 was absent of vital signs. LPN #521 documented that, upon verification of the resident's code status of full code, emergency protocol was initiated. A Code Blue (a medical emergency signal indicating a cardiac or respiratory arrest) was paged overhead. A second nurse and a certified nurse aide (CNA) came to assist with the emergency bringing the crash cart (a cart where lifesaving equipment is stored) with them. The second nurse went to call 911 and print out the paperwork needed. Approximately 10 minutes after calling 911, EMS arrived and took over CPR. EMS was not notified that the resident was on hospice but there was still a full code. LPN #521 documented after several rounds of CPR, the lead EMS called the emergency physician and confirmed the time of death. Interview with Medical Director (MD) #614 on [DATE] at 12:27 P.M. revealed Resident #13 was a full code but his wishes were not congruous with his physical status. It was an ongoing conversation between the resident and hospice. MD #614 said Resident #13 was not ready to accept his desire to be a full code did not match with his not wanting to go to the hospital again, especially since he had just been discharged from the hospital recently. MD #614 said he was not made aware by the facility that Resident #13 had a coffee ground emesis, had been hypotensive and tachycardic that day. All he was told was that the resident had vomited and then felt better. If he had been notified of the resident's condition he would have advised Resident #13 be sent to the emergency room (ER) for evaluation since he was a full code. 2. Resident #85 was admitted to the facility on [DATE] with diagnoses including diabetes, COPD, heart disease, high blood pressure, and hemiplegia and hemiparesis to the left nondominant side following a stroke. Review of the physician's orders for Resident #85 revealed an order dated [DATE] for the resident to be a full code. Review of the comprehensive quarterly MDS 3.0 assessment, dated [DATE], revealed Resident #85 was independent for all personal care, had no pain, and did not have a life expectancy of less than six months. The resident had now wounds and was receiving no special treatment of any sort. Review of the nursing progress notes for Resident #85 revealed on [DATE] at 10:20 A.M. LPN (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#634 was in the resident's room during morning medication administration. Resident #85 complained of chest pain and constipation. LPN #634 checked the resident's vital signs and obtained a blood pressure of 140/80, a heart rate of 84, and an oxygenation level of 96% on room air. LPN #634 advised the resident to go to the emergency room (ER) by 911. Resident #85 refused saying he knew his pain was due to being constipated. The resident was offered an as needed breathing treatment and Miralax for the constipation. LPN #634 documented on [DATE] at 11:03 A.M. that she was notified by housekeeping Resident #85 was on the floor in the bathroom. Upon entering the bathroom LPN #634 found the resident lying face down on the floor and was unresponsive. LPN #634 attempted to obtain vitals without success but the resident did have a weak pulse. LPN #634 initiated cardiopulmonary resuscitation (CPR) and 911 was called. The resident was placed on 10 liters of oxygen via a nonrebreather mask and also suctioned him at 11:10 A.M. Emergency Medical Services (EMS) arrived at 11:16 A.M. and took over CPR from LPN #634. He was transferred to the ER at 11:26 A.M. No documentation was found indicating the facility notified MD #614 of the resident's complaint of chest pain. Interview with MD #614 on [DATE] at 11:35 A.M. revealed he had not been notified Resident #85 was having chest pain 40 minutes prior to being found unresponsive. MD #614 did have a history of being noncompliant with care but said he should have been notified the resident was having chest pain. Review of the facility's Change in a Resident's Condition or Status, last updated [DATE], revealed the nurse will notify the resident's physician when there has been a(an): accident or incident involving the resident; discovery of injuries of an unknown source; adverse reaction to medication; a significant change in the resident's physical/emotional/mental condition; a need to alter the resident's medical treatment significantly; refusal of treatment or medications two or more consecutive times; a need to transfer the resident to a hospital/treatment center; discharge without proper medical authority; and a specific instruction to notify the physician of changes in the resident's condition. A significant change of condition is a major decline or improvement in the resident's status that: will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of the resident's health status; requires interdisciplinary review and/or revision to the care plan; and ultimately is based on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument. This deficiency represents noncompliance investigated under Complaint Number 1381901.		

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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 review of facility policy, the facility did not ensure Resident #55's care plan was revised to include physician ordered oxygen therapy. This affected one resident (#55) of 22 residents reviewed for care plans. The facility identified three residents (#5, #39 and #55) who required oxygen therapy. The facility census was 53. Findings included: Review of the medical record for Resident #55 revealed a date of admission of 04/25/25 with diagnoses including emphysema and asthma. Review of Resident #55's physician orders revealed an order dated 05/23/25 for oxygen at two liters per minute via nasal cannula. Review of the quarterly minimum data set 3.0 assessment dated [DATE] revealed Resident #55 was cognitively intact. The assessment also revealed oxygen therapy in use. Review of the care plan, date initiated 04/29/25, revealed Resident #55 had emphysema and chronic obstructive pulmonary disease. Interventions included keep the head of the bed elevated for shortness of breath to facilitate ease of breathing, monitor for difficulty breathing on exertion, and monitor for signs and symptoms of acute respiratory insufficiency. There were no interventions noted within the care plan for the oxygen therapy ordered on 05/23/25. On 08/21/25 at 1:57 P.M. an interview with Registered Nurse #604 verified Resident #55 did not have a care plan in place for the oxygen therapy. A review of the policy titled Care Plans, Comprehensive Person Centered, dated 12/2016, revealed the comprehensive, person-centered care plan would include measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs and be developed and implemented for each resident. The policy also stated the comprehensive, person-centered care plan would describe the services that are to be furnished to attain or maintain the residence's highest practicable, physical, mental and psychosocial well-being and was derived from a thorough analysis of information gathered as part of the comprehensive assessment.		

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NAME OF PROVIDER OR SUPPLIER Gardens of Euclid Beach		STREET ADDRESS, CITY, STATE, ZIP CODE 16101 Euclid Beach Blvd Cleveland, OH 44110	
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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interviews, the facility failed to ensure Resident #29 was provided corrective lens and vision care appointments per physician orders. This affected one resident (Resident #29) of one resident reviewed for vision services. The facility census was 53. Findings include: Review of the medical record for Resident #29 revealed an admission date of [DATE] with diagnoses including diabetes mellitus with proliferative diabetic retinopathy with bilateral macular edema. Review of the [DATE] quarterly Minimum Data Set (MDS) 3.0 assessment for Resident #29 revealed a Brief Interview of Mental Status (BIMS) score of four out of 15 which indicated severe cognitive impairment. Resident #29 was noted under Section B to have adequate vision with corrective lenses. Review of the care plan for Resident #29 which was last reviewed on [DATE] revealed impaired visual function related to hypertension and diabetes. Interventions listed were to arrange consultation with an eye care practitioner as required. Review of the physician order dated [DATE] from Resident #29's optometrist revealed a prescription for glasses with an expiration date of [DATE]. Review of the physician order dated [DATE] for Resident #29 revealed an order for an optometrist appointment on [DATE] at 9:10 A.M. Review of the nursing progress notes from [DATE] to [DATE] did not reveal any evidence that Resident #29 went to the appointment with the optometrist on [DATE] or if it had been rescheduled within that time frame. Review of the outside ophthalmologist physician notes dated [DATE] for Resident #29 revealed a diagnosis of proliferative diabetic retinopathy of both eyes with macular edema associated with type two diabetes mellitus and bilateral pseudophakia (condition where the natural lens of the eye has been replaced with an artificial intraocular lens). Recommendations were to return for a follow-up appointment in five to seven months. Review of the physician order dated [DATE] revealed an order for an eye appointment at the outside ophthalmologist on [DATE] at 8:15 A.M. Further review of the medical record for Resident #29 revealed no documentation to show he attended the [DATE] ophthalmologist appointment. Review of the nursing progress notes for Resident #29 did not reveal any evidence of why Resident #29 did not attend the physician ordered appointment on [DATE] or if it was rescheduled. A phone interview was conducted on [DATE] at 3:58 P.M. with Resident #29's Power of Attorney (POA) and revealed she had reported Resident #29's missing glasses last week but had not heard any additional information since then. Resident #29's POA stated he went on a leave of absence (LOA) from the facility in mid-July, did not have his glasses on when he was picked up and she had not seen the glasses during recent visits. An observation on [DATE] at 4:15 P.M. of Resident #29 revealed he was sitting up in his bed and was not wearing his glasses. Interview at the time of the observation with Resident #29 revealed his glasses had been missing for a while but he was unsure how long. An observation on [DATE] at 4:20 P.M. with Certified Nursing Aide (CNA) #562 revealed she was unable to locate Resident #29's glasses in his room and was unaware his glasses were missing. An interview on [DATE] at 7:26 A.M. with Director of Nursing (DON) #581 confirmed she was made aware of Resident #29's missing glasses yesterday and was unable to order replacement glasses because his prescription was expired. DON #581 stated there was a physician order dated [DATE] to schedule an eye exam with no directions specified in the order. DON #581 confirmed the nurse should have called to schedule an eye exam when the order was placed. An interview on [DATE] at 9:10 A.M. with DON #581 confirmed she was unable to provide additional evidence related to the [DATE] eye appointment for Resident #29 or why it was not kept or rescheduled. An interview on [DATE] at 1:45 P.M. with Regional Director of Clinical Services (RDSCS) #601 and Regional Director of Operations (RDO) #599 confirmed the facility was unable to provide evidence why Resident #29 did not attend the [DATE] ophthalmologist appointment or why a follow up had not been scheduled since then. Interview on [DATE] at 2:47 P.M. with RDSCS #601 and RDO #599 confirmed they were unable to provide a facility policy related to vision appointments, ancillary appointments or physician orders (continued on next page)		

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

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	being followed.This deficiency represents noncompliance investigated under Complaint Number 1381901 and Complaint Number 1381896.		

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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, record review, clinical nursing assistant orientation program staff sign off review, interview and facility policy review, the facility failed to ensure appropriate supervision was provided for residents requiring supervision while smoking and failed to ensure residents did not have smoking items in their personal possession. This affected two residents (Resident #45 and #49) of three residents reviewed for smoking. The facility identified 26 residents (Residents #4, #5, #6, #7, #12, #13, #14, #15, #17, #18, #22, #26, #40, #41, #43, #44, #45, #49, #50, #51, #52, #53, #54, #60, #61, and #63) who smoked. The facility census was 53. Findings include: Observation on 08/18/25 at 2:25 P.M. of the outside smoking area revealed three residents (Resident #45, #49 and #60) smoking outside without supervision. At the time of the observation, the Administrator confirmed residents were without staff supervision and stated he did not know if those resident's required supervision, but if they required supervised smoking, a staff member should have been present. Review of the facility approved smoking times included 9:10 A.M.-9:30 A.M., 11:00 A.M.-11:20 A.M., 1:30 P.M.-1:50 P.M., 3:30-3:50 P.M., 6:30 P.M.-6:50 P.M. and 7:40 P.M.-8:00 P.M. Review of the 08/19/25 facility resident smoker list revealed only two residents (Resident #12 and #51) of 26 residents listed as requiring smoking supervision. (However, Residents #12 and #51 were also assessed as requiring supervision). 1. Review of the medical record for Resident #45 revealed and admission date of 11/23/17. Diagnoses included acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure, chronic obstructive pulmonary disease (COPD), vascular dementia, schizophrenia and nicotine dependence. Review of the 02/06/25 signed facility smoking policy resident contract for Resident #45 revealed any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff member at all times while smoking. Residents with restricted smoking privileges are not permitted to keep cigarettes, and other smoking articles in their possession. Review of the 05/29/25 smoking safety screen for Resident #45 revealed supervision was required for safe smoking. Review of the 06/11/25 Minimum Data Set (MDS) 3.0 assessment for Resident #45 revealed intact cognition. Resident #45 was noted to require supervision for walking 150 feet and was independent for most activities of daily living (ADL). Review of the care plan for Resident #45 which was last reviewed on 07/08/25 revealed Resident #45 had a history of smoking in the community and in the facility. Interventions listed included complete a smoking evaluation per facility guidelines, and the resident will follow the facility smoking policy. Observation on 08/28/25 at 8:11 A.M. in Resident #45's room revealed Resident #45 sitting on his bed and an empty pack of cigarettes and a lighter on his bedside table. Interview at the time of the observation with Resident #45 revealed he did not have any more cigarettes but had taken the cigarette lighter from a table in the outside smoking area and was going to dispose of it but had not done it yet. At the time of the observation, Director of Nursing (DON) #581 confirmed the smoking items in Resident #45's room and confirmed he was not supposed to have smoking items in his possession. 2. Review of the medical record for Resident #49 revealed an admission date of 12/12/23. Diagnoses included malignant neoplasm of lower lobe of the right lung, COPD and nicotine dependence. Review of the 02/06/25 signed facility smoking policy resident contract for Resident #49 revealed any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff member at all times while smoking. Residents with restricted smoking privileges are not permitted to keep cigarettes, and other smoking articles in their possession. Review of the 05/29/25 smoking safety screen for Resident #49 revealed supervision was required for safe smoking. Review of Resident #49's care plan last reviewed on 06/12/25 revealed Resident #49 had a history of smoking in the community and in the facility. Interventions listed included complete a smoking evaluation per facility guidelines, and the resident will follow the facility smoking policy. Review of the 08/09/25 quarterly MDS 3.0 assessment revealed Resident #49 had intact cognition and was independent for ADL. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/28/25 at 8:30 A.M. with Resident #49 who was sitting in his wheelchair next to the nurses' station revealed he thought he was at a credit union and was looking for donations. When Resident #49 was asked where he kept his money, Resident #49 proceeded to roll up the seat cushion on the left side of his wheelchair which revealed a pack of cigarettes. DON #581 was standing at the nurses' station at the time of the observation and confirmed Resident #49 had cigarettes in his possession and was not supposed to. Review of the undated clinical nursing assistant orientation program staff sign off sheet revealed staff are oriented to resident smoking locations, times, protocols and safety as part of the 'on the floor' competencies. Review of the facility policy called Smoking Policy-Residents Acknowledgement, revised December 2016, revealed prior to and upon admission, residents shall be informed of the facility smoking policy, and designated smoking areas. Smoking is only permitted in the designated resident smoking area which is located outside of the building. Smoking is only permitted during designated times for residents that require supervision. Upon admission the resident will be evaluated to determine if he or she is a smoker or non-smoker and ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation). Any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff member at all times while smoking. Residents with restricted smoking privileges are not permitted to keep cigarettes, pipes or other smoking articles in their possession. This deficiency represents noncompliance investigated under Complaint Numbers 2578214 and 1381901.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and facility policy review, the facility failed to ensure oxygen tubing was dated as changed weekly for equipment management and infection control. This affected two residents (Resident #39 and Resident #55) of three residents (Residents #5, #39 and #55) identified by the facility as utilizing oxygen. The facility census was 53. Findings include: 1. A review of the medical record for Resident #39 revealed a date of admission of 06/28/23. Significant diagnosis included acute respiratory failure with hypercapnia (a buildup of carbon dioxide in the bloodstream). Significant orders included oxygen at four liters per minute at bedtime and as needed to keep oxygen level above 92 percent, change oxygen tubing every Tuesday for respiratory equipment management and infection control. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #39 was cognitively intact. The assessment also revealed oxygen therapy in use. Review of the care plan dated 07/11/25 revealed Resident #39 had oxygen therapy. Interventions included oxygen at two to four liters per minute. On 08/20/25 at 9:00 A.M. an observation of Resident #39 revealed him lying in bed with oxygen applied via nasal cannula. The oxygen tubing was undated. On 08/20/25 at 3:00 P.M. an observation of Resident #39 revealed him lying in bed with oxygen applied via nasal cannula. The oxygen tubing was undated. Licensed Practical Nurse (LPN) #506 verified the undated oxygen tubing at the time of the observation. 2. A review of the medical record for Resident #55 revealed a date of admission of 04/25/25. Significant diagnoses included emphysema and asthma. Significant orders included oxygen at two liters per minute via nasal cannula. There were no orders to change oxygen tubing weekly. Review of the care plan dated 04/29/25 revealed Resident #55 had emphysema and chronic obstructive pulmonary disease. Interventions included keeping the head of the bed elevated for shortness of breath to facilitate ease of breathing, monitor for difficulty breathing on exertion, and monitor for signs and symptoms of acute respiratory insufficiency. There were no interventions noted within the care plan for oxygen use. Review of the quarterly MDS assessment dated [DATE] revealed Resident #55 was cognitively intact. The assessment also revealed oxygen therapy in use. On 08/18/25 at 1:12 P.M. an observation of Resident #55 revealed him sitting in a wheelchair with oxygen applied. The oxygen tubing was not dated as to when it was changed. A plastic bag hanging on the oxygen concentrator was dated 08/08/25. On 08/20/25 at 10:00 A.M. an observation of the oxygen tubing coming from the oxygen concentrator was undated. The plastic bag hanging on the concentrator was dated 08/08/25. An interview with LPN #559 at the time of the observation verified the lack of a date on the oxygen tubing. LPN #559 also verified the date of 08/08/25 on the plastic bag hanging on the oxygen concentrator. When asked if this was the date the oxygen tubing was changed, LPN #559 stated yes. A review of the policy titled; Changing Oxygen Tubing, dated 09/2020, revealed The facility shall change oxygen tubing per infection standards of practice. Residents who receive oxygen therapy will have their tubing changed every seven days and as needed. Oxygen tubing will be dated and initialed with changing.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to ensure monthly pharmacy reviews were completed for two residents (Residents #4 and #53) of five reviewed for unnecessary medications. The facility census was 53. Findings include: 1. Review of the medical record for Resident #53 revealed an admission date of 09/08/23. Diagnoses included hemiplegia and hemiparesis affecting the left non-dominant side, type II diabetes mellitus, history of suicidal behavior, alcohol abuse and cocaine abuse. Review of the physician order dated 01/29/25 for Resident #53 revealed an order for Sertraline Hydrochloride (an antidepressant) 75 milligrams (mg) mg by mouth one time a day for depression. Review of the physician order dated 04/01/25 for Resident #53 revealed an order for Depakote sprinkles (an anticonvulsant) capsule delayed release 125 mg, give one capsule by mouth two times a day for mood stabilization. Review of the physician order dated 05/02/25 for Resident #53 revealed an order for aspirin (antiplatelet) 81 mg oral tableted to be given daily. Review of the care plan last reviewed on 07/23/25 for Resident #53 revealed risk for adverse effects related to use of psychoactive medications for diagnosis of depression. Interventions included evaluating effectiveness and side effects of medications for possible decrease/elimination. Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #53 had a Brief Interview for Mental Status (BIMS) score of nine out of 15 which indicated moderate cognitive impairment. Resident #53 was also noted to have a diagnosis of depression and received antidepressant, antiplatelet and anticonvulsant medications. Review of the medical record for Resident #53 from 08/2024 to 08/2025 revealed only two monthly pharmacist medication reviews completed on 07/24/25 and 08/24/25. No additional evidence of monthly pharmacy reviews was found in the medical record. On 08/21/25 an interview with Director of Clinical Services (DCS) #601 revealed the only pharmacy reviews that could be located for the facility were from April 2025 through July of 2025. Stated he was unable to locate any medication regimen reviews for the facility prior to April of 2025. 2. Review of the medical record for Resident #4 revealed an initial date of admission of 11/23/21. Significant diagnoses included multiple sclerosis, diabetes mellitus type two, unspecified vascular dementia, unspecified depression, cognitive communication deficit, neuromuscular dysfunction of the bladder, and long-term use of insulin. Significant orders included glargine insulin 100 units per milliliter, inject 10 units subcutaneously at bedtimes for diabetes mellitus, lispro insulin 100 units per milliliter, inject per sliding scale, if blood sugar between 151 and 200 inject 2 units, if blood sugar between 201 and 250 inject 4 units, if blood sugar between 251 and 300 injects 6 units, if blood sugar between 301 and 350 inject 8 units, and if blood sugar between 351 to 400 inject 10 units subcutaneously with meals, and Zoloft (an antidepressant) 125 mg daily related to depression. Review of the care plan dated 05/28/25 revealed Resident #4 was at risk for adverse effects related (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to use of psychoactive medication for diagnoses of anxiety, depression, and sleep disorder. Interventions included evaluate effectiveness and side effects of medications for possible decrease or elimination of psychotropic drugs. The care plan further revealed Resident #4 was at risk for complications of non-insulin dependent diabetes mellitus with peripheral vascular disease and diagnosis of peripheral angiopathy with need for routine insulin and oral hypoglycemic use. Interventions included administering medications as ordered and monitor for adverse effects of medication. Review of the quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15 indicating Resident #4 was cognitively intact. The assessment also revealed insulin use and antidepressant use. Review of the progress notes revealed pharmacy reviews on 07/24/25 and 08/24/25. There was no documentation evidence of recommendations for the aforementioned dates. There was no previous pharmacy reviews noted in the progress notes. The last one documented was 12/17/21. On 08/21/15 an interview with Director of Clinical Services (DCS) #601 revealed the only pharmacy reviews that could be located for the facility were from April 2025 through July of 2025. Stated he was unable to locate any medication regimen reviews for the facility prior to April of 2025. Review of the facility policy titled; Medication Regimen Review, dated 04/2007, revealed the consultant pharmacist shall review the medication regimen of each resident at least monthly. The primary purpose of this review is to help the facility maintain each residence's highest practicable level of functioning by helping them utilize medications appropriately and prevent or minimize adverse consequences related to medication therapy to the extent possible. As part of the medication regimen review, the consultant pharmacist will determine if the resident is receiving the correct medications as ordered and be alert to medications with potentially significant medication related adverse consequences. The consultant pharmacist will document his or her findings and recommendations on the monthly drug/medication regimen review report. The consultant pharmacist will provide a written report to physicians for each resident with an identified irregularity. The consultant pharmacist will provide the director of nursing services and medical director with a written, signed and dated copy of the report, listing the irregularities found and recommendations for their solutions. Copies of the drug medication regimen review reports, including physician responses, will be maintained as part of the permanent medical record.		

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure physician ordered labs were completed timely as required. This affected one resident (Resident #53) of 22 residents reviewed for physician orders. The facility census was 53. Findings include: Review of the medical record for Resident #53 revealed an admission date of 09/08/23. Diagnoses included hemiplegia and hemiparesis affecting the left non-dominant side, type II diabetes mellitus, history of suicidal behavior, alcohol abuse and cocaine abuse. Review of the physician order dated 11/21/23 for Resident #53 revealed an order for a BMP (Basic Metabolic Panel) and CBC (Complete Blood Count) to be completed every three months with no further directions specified. Review of the medical record for Resident #53 revealed no evidence of a BMP or CBC being completed on 07/15/25 as ordered. Review of the care plan last reviewed on 07/23/25 for Resident #53 revealed resident at risk for adverse effects related to use of psychoactive medications and diagnosis of depression. Resident #53 also had a diagnosis of depression related to pain management needs. Intervention for both listed included obtain lab results as ordered and notify the physician of abnormal values. Review of the 08/15/25 annual Minimum Data Set (MDS) 3.0 assessment for Resident #53 revealed a Brief Interview for Mental Status (BIMS) score of nine out of 15 which indicated moderate cognitive impairment. Resident #53 was also noted to have a diagnosis of depression and received antidepressant, antiplatelet and anticonvulsant medications. Interview on 08/25/25 at 3:14 P.M. with Regional Director of Clinical [NAME] (RDCS) #601 confirmed the BMP and CBC was last completed on 04/15/25 but was unable to provide evidence that the BMP and CBC were completed as physician ordered on 07/2025. Interview on 09/03/25 at 2:47 P.M. with RDCS #601 and Regional Director of Operations (RDO) #599 confirmed they were unable to provide a facility policy related to physician orders being followed. This deficiency represents noncompliance investigated under Complaint Number 1381901.		