

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365597	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/20/2026
NAME OF PROVIDER OR SUPPLIER Westmoreland Place		STREET ADDRESS, CITY, STATE, ZIP CODE 230 Cherry St Chillicothe, OH 45601	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on facility staffing schedules and staff interview, this facility failed to ensure the facility had Registered Nurse (RN) coverage for eight consecutive hours for four days out of the last two months. This had the potential to affect all 84 residents currently residing at this facility. Findings include: Review of the daily staffing posted numbers revealed on 05/10/2026, 05/17/2026, 06/27/2026, and 06/28/2026 the facility did not have a Registered Nurse scheduled for the day shift or night shift. Interview 07/20/2026 at 12:55 P.M. with the Director of Nursing (DON) confirmed the facility did not have the required RN coverage on 05/10/2026, 05/17/2026, and 06/27/2026, and 06/28/2026 as required. The DON confirmed the facility did use staffing agencies for fill open shifts including for RN coverage, but a staffing agency had not been used for the above dates.		

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and facility policy review, the facility failed to ensure food was stored appropriately. This had the potential to affect all residents. The facility census was 84. Findings include: Observation and interview on 07/13/2026 at 8:54 A.M. to 9:30 A.M. with the Dietary Manager (DM) #301 in the kitchen revealed all the floors throughout the entire kitchen area were dirty, the freezer had a half of box of cookies opened and undated on the shelf and there was one bag of chicken opened and undated on the shelf. Observation of the refrigerator revealed 13 rotten cucumbers on a tray uncovered and ready for use. The DM #301 confirmed the freezer had a half a box of cookies opened and undated on the shelf and one bag of chicken opened and undated on the shelf. The DM #301 confirmed the refrigerator had 13 rotten cucumbers on a tray uncovered and ready for use. The DM #301 further confirmed the floors are dirty in the entire kitchen area. Review of the policy titled, Food Receiving and Storage, dated 11/2022, revealed foods shall be received and stored in a manner that complies with safe food handling practices. Non-refrigerated foods, disposable dishware and napkins are stored in a designated dry storage unit which is temperature and humidity controlled, free of insects and rodents and kept clean. All foods in the refrigerator or freezer are covered, labeled and dated.		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview and policy review, the facility failed to ensure the kitchen was free from flies. This had the potential to affect all residents. The facility census was 84. Findings include: Observation and interview on 07/13/2026 at 8:54 A.M. to 9:30 A.M. with the Dietary Manager (DM) #301 revealed there were many flies in the kitchen and the air conditioning unit in the kitchen is in the window with a small opening to the outside. The DM #301 confirmed many flies throughout the entire kitchen area, including storage and preparation areas. Interview on 07/14/26 at 10:54 A.M. with Dietician #412 stated flies are bad, observed multiple flies on the preparation table area during tray preparation for residents meal. Interview on 07/14/26 at 11:05 A.M. with [NAME] #200 while preparing a tray the [NAME] #200 swatted a fly away and stated the flies are a problem in the kitchen. Interview on 07/14/26 at 11:53 A.M. with the Dietician #412 stated the flies in the kitchen are an infestation. Interview on 07/15/26 at 8:46 A.M. with the Maintenance Director (MD) #226 revealed they were unaware of the opening where the air conditioning unit is in the window and flies are getting in. Review of the policy titled, Food Receiving and Storage, dated 11/2022 revealed foods shall be received and stored in a manner that complies with safe handling practices. Review of the policy titled, Pest Control, undated revealed the facility shall maintain an effective, ongoing pest control program to ensure the nursing home environment remains free from insects, rodents, and other pests in order to protect the health, safety, and well-being of residents, staff and visitors. The program shall include routine monitoring, inspection, and corrective actions to ensure the environment remains pest free. Cracks, gaps and penetrations shall be sealed as identified through routine inspection.		

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and staff record review, the facility failed to ensure the required annual training was completed for three Certified Nurse Aides (CNA) (#242, #221, #413). Further, the facility failed to ensure the additional training for the care of the cognitively impaired was completed for three CNA's (#239, #414, #277). This had the potential to affect all residents. The facility census was 84. Findings include: Review of the staff record for CNA #242 revealed a hire date of 01/30/13 and no documentation of the annual training for CNA #242 was completed. Review of the staff record for CNA #221 revealed a hire date of 05/24/24 and no documentation of the annual training for CNA #241 was completed. Review of the staff record for CNA #413 revealed a hire date of 08/25/23 and no documentation of the annual training for CNA #413 was completed. Review of the staff record for CNA #239 revealed a hire date of 10/31/25 and no documentation of the training for the care of the cognitively impaired for CNA #239 was completed. Review of the staff record for CNA #414 revealed a hire date of 04/24/26 and no documentation of the training for the care of the cognitively impaired for CNA #414 was completed. Review of the staff record for CNA #277 revealed a hire date of 08/20/25 and no documentation of the training for the care of the cognitively impaired for CNA #277 was completed. Interview on 07/20/26 at 2:45 P.M. with the Administrator verified there is no documented annual trainings and for CNA's (#242, #221, #413) and no documented training for the care of the cognitively impaired for CNA's (#239, #414, #277).		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the resident council meeting minutes, residents interviews, staff interviews and review of the facility policy, the facility failed to ensure resident and family concerns were addressed in a timely manner. This affected 10 Resident (#7, #9, #20, #25, #32, #43, #45, #68, #69, and #82). Facility census was 84. Findings include: Review of the Resident council meeting minutes dated 07/24/25 revealed concerns that a resident room was not cleaned except when one specific housekeeping staff person was on the scheduled response with a plan to educate the staff to remind the resident when their room is being cleaned to step out. The residents reported they were not getting enough snacks in the evening and also revealed aides were only giving snacks to certain residents and not everyone with the response to add more snacks to the cart and talk to the dietary manager about snack issues. They voiced concern of staff being on their phones when in the hallway with a plan to educate staff on the cell phone policies. Review of the Resident council meeting minutes dated 08/28/25 revealed concerns related to cooking too much or too little and not providing sauces on meal trays with a plan to cook food for the correct amount of time and to place sauces on trays. The residents reported concerns related to a problem with an aide and requesting she not work on a certain floor, aides being on their phones and sitting in the dining room on their phones and being rude and sleeping during their shift and not answering call lights with a response educate staff. Review of the Resident council meeting minutes dated 09/25/25 revealed a concern the peanut butter and jelly sandwiches do not have enough filling and revealed it was mostly just bread, a response/ plan to educate the staff to add more filling. Review of the Resident council meeting minutes dated 10/23/25 revealed a resident report that night staff treat residents like they were inmates, poor communication at shift changes, residents being left for 45 minutes in the shower, aides taking personal calls in front of residents, not giving medications on time and giving inaccurate medications. The facility responses included educating staff (including agency staff) on customer service, communication, activity of daily living, and the cell phone policy and the facility fired an agency nurse for issues with medication administration. Review of the Resident council meeting minutes dated 11/20/25 revealed a request for air fresheners for resident bathrooms with a response that residents cannot have any chemicals. They reported food was overcooked and wanted some menu changes with response for adjusted cooking times and menu changes to occur. Residents also reported they have to remind agency staff when they did not get all their medications and reports of staff not treating residents with respect with a plan to educate staff on medication pass in the electronic record and on customer service. Review of the Resident council meeting minutes dated 12/18/25 revealed a resident concern related to not getting medications as ordered with response to educate staff on medication administration. Residents also reported staff were grumpy and loud with a plan to educate staff on customer service. Review of the Resident council meeting minutes dated 01/22/26 revealed concerns that laundry was slow to be returned with response the facility no longer had a second shift laundry staff member. They also voiced two residents requested copies of their medical records with the response one of the two residents were provided a release of information form. It did not include any mention about the second resident's request. They voiced concern of staff (nurses and aides) were vaping in the building with a response to educate staff about vapes and instruction to residents to tell manager specific names of nursing aides they can be addressed separately. Review of the Resident council meeting minutes dated 02/26/26 revealed concerns that a resident room was not cleaned on the weekend with response they attempted twice and the resident was speaking with his counselor. (continued on next page)		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The residents requested seasoning on their food with the response to put salt and pepper packs on trays. They voiced concern of a specific staff member vaping at the nursing station with a response to speak with the specific staff member and educate her about facility policy. The residents brought up concern regarding having enough staffing and having two aides at night but only one during the day with a response that staffing was based on facility need. Review of the Resident council meeting minutes dated 03/26/26 revealed concerns that residents were not getting salt and pepper with a plan to have staff put the seasoning on meal trays. They voiced concern of a specific staff member being rude to residents and staff asked for an accurate name as they had no staff by the name provided. They reported concerns related to a resident requesting medication at 2:00 P.M. and the nurse said she was busy and was on her phone. The facility responded, stating staff can administer medications from 1:00 P.M. to 3:00 P.M. to meet the guidelines and informed him the staff may use phones for work-related reasons or may have been on break. The residents reported staff (aides) have been on their phones and not answering call lights with a response for staff to be educated about phones cane call lights. Review of the Resident council meeting minutes dated 04/23/26 revealed concerns from the previous meeting were not resolved, including residents not getting condiments with meals with a plan to educate the staff again. They discussed the peanut butter, and jelly sandwiches had no peanut butter and jelly with a plan to instruct staff to add more filling. Residents also requested different items on the snack cart and were instructed they would try when the budget allowed. The residents reported they were seeing staff vaping in the building with a plan to remind staff to vape outside in designated smoking areas. Review of the Resident council meeting minutes dated 06/25/26 revealed concerns that a resident room was not cleaned and the resident was having to empty his own trash with a response for the housekeeping manager to check the room after it is cleaned to make sure it was done. Interview on 07/15/26 at 11:04 A.M. with the Administrator revealed the facility responses are documented on the resident council meeting minutes and confirmed she was not aware of any additional documentation or evidence of follow up including training sign in sheets or audits. The meeting minutes were reviewed and the Administrator confirmed they lacked detail of follow up to address the concerns. She acknowledged residents requesting air fresheners and were told no as residents could not have access to chemicals, but confirmed the facility had no documentation asking why they wanted air fresheners or looking into a cleanliness issue. She also confirmed an incidence of two residents requesting access to their medical records and it was documented, only one was given information. She confirmed facility should address concerns, so they are not brought up month after month. Interview and observation on 07/15/26 at 12:30 P.M. with Residents #25, #32 and #69 revealed concerns related to the facility not addressing resident concerns. They reported they bring up some of the same items over and over again and reported the facility management does not do enough to fix issues and reported it felt they were being brushed off. They confirmed issues related to staffing, smoking, cell phone use, snacks and peanut butter and jelly sandwiches, medication administration and housekeeping issues are regular issues that remain ongoing. Resident #69 had [NAME] a Peanut butter and jelly sandwich to the meeting and jelly was only seen in one corner of the sandwich and had barely any peanut butter on it. Interview on 07/15/26 at 2:00 P.M. with Activity Director #270 confirmed the previous administrator did not encourage documentation and follow up of resident concerns and did not want her to document concerns on the meeting minutes. She confirmed facility had a lack of follow up and revealed she provides an update to each department head of the issues brought up and they can provide her with information on their follow up. She confirmed the same items are repeated over and over again including concerns related to staff treatment of residents (being rude), concerns related to the amount (continued on next page)		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of staff, staff vaping inside the facility, staff being on their phones, food being cooked properly, snacks not being provided, condiments and seasoning not being provided, and the peanut butter and jelly sandwiches having minimal filling. The activity director acknowledged they stated education for just about every complaint and also acknowledged if staff were educated and it was still happening; they should be trying other interventions including auditing and checking on staff and residents frequently. The activity director confirmed facility did not have a process to fix resident concerns. Review of the facility policy titled, Resident Concerns and Grievance Management Policy dated 09/30/25 revealed the facility shall establish a process to identify, document, investigate, track and resolve resident concerns and grievances and concerns. The process should include documentation of the concern, assigning follow-up, and documentation of resolution and maintain records for survey readiness. This deficiency represents non-compliance investigated under Complaint Number 2983546 and 2709514.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interview, the facility failed to ensure a homelike environment for four residents (#13, #35, #47, and #81) of six reviewed for environment. Facility census was 84. Findings include : 1. Interview and observation on 07/09/26 at 10:18 A.M. with Housekeeping Supervisor #266 confirmed the air conditioner (ac) window unit for Resident #35 had holes to the outside surrounding the unit and were not secured except with duct tape. She also confirmed there was a board covering the rest of the window that was also duct taped to the window sill. She confirmed it was not homelike to have a board and window ac unit duct taped to the wall. Observation on 07/09/26 at 10:22 A.M. revealed Resident #81 was sleeping in her room. Her window unit was secured with a board and duct tape. Observation on 07/09/26 at 10:27 A.M. revealed Resident #47's window ac unit was held in with duct tape. Interview and observation 07/09/26 at 12:05 P.M. with Maintenance Director #226 confirmed the facility had window ac units in place that were not fully sealed. He confirmed the board placed on the other part of the window was a piece of vinyl and confirmed they were held by duct tape or masking tape to hold it in place and confirmed you could see outside. He acknowledged this was not homelike to have window units held by duct tape with holes to the outside. Interview on 07/09/26 at 4:00 P.M. with Regional Support #404 acknowledged ac units installed with duct tape with unsealed areas was not a homelike environment. 2. Review of the medical record revealed Resident #13 was admitted to the facility on [DATE]. Diagnoses included anxiety, raynaud's syndrome, thoracic aortic aneurysm, major depressive disorder and alzheimer's disease. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #13 had severely impaired cognition, and partial assistance with toileting and bathing. Interview and observation on 07/13/26 at 10:49 A.M. in Resident #13's room with Resident #13 revealed a large area approximately three foot by three foot next to Resident #13's bed had paint chipped off from the head of the bed to the foot of the bed. Resident #13 stated the area that has paint chipped off looks nasty and bothers her. Interview on 07/13/2026 10:50 AM with Licensed Practical Nurse (LPN) #220 confirmed the large area, approximately three foot by three foot next to Resident #13's bed had paint chipped off from the head of the bed to the foot of the bed. Interview on 07/15/26 at 7:57 A.M. with the Administrator confirmed the area with chipped paint in (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #13's room. This deficiency represents non-compliance investigated under Complaint Number 3073628, 2686126 and 2983546.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 staff interview and record reviews, the facility failed to ensure care conferences were completed quarterly for Resident #11. This affected one of one resident investigated for care conferences. The facility identified 32 other residents that had not had a care conference completed in the second quarter of 2026 (Residents #2, #6, #7, #9, #12, #13, #14, #16, #17, #18, #19, #20, #21, #22, #24, #25, #27, #28, #29, #30, #31, #32, #33, #34, #36, #37, #38, #39, #40, #41, #44, and #98). The facility census was 84. Review of Resident #11's medical record revealed the resident was admitted [DATE] with intact cognition and had diagnoses that included fibromyalgia, chronic respiratory failure, and atherosclerotic heart disease. Review of Resident #11's most recent care conference notes revealed a care conference was held on 10/13/25 and 01/16/26. Care conference notes for both conferences revealed the resident was not in attendance at the care conference. Review of care conference list received from Administrator revealed Resident #11's next care conference was scheduled for 07/17/26, along with scheduled dates for other residents who did not have a care conference in the second quarter of 2026. Interview on 7/16/26 at 12:46 P.M. with Licensed Social Worker (LSW) #406 confirmed no care conference was completed since 01/16/26 for Resident #11. LSW #406 confirmed that the facility had no social worker for a short time and many second quarter care conferences were not scheduled because of no staff in the social services position. Review of facility policy titled Participation in Care Conferences dated 02/10/25 revealed each long-term, resident will have a care conference with the IDT scheduled quarterly, annually, and with any significant changes.		

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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 record review, the facility failed to ensure medications were stored appropriately and that medication carts were free from expired medications. This affected the following 49 residents receiving medications from the three medication carts observed: Residents #3, #4, #6, #7, #8, #10, #11, #12, #14, #16, #19, #23, #25, #28, #29, #30, #31, #32, #33, #35, #37, #38, #39, #40, #41, #44, #45, #48, #50, #54, #55, #57, #59, #60, #61, #62, #63, #64, #67, #68, #69, #70, #71, #72, #75, #84, #85, #88, and #97. Facility also failed to ensure prescription medication was not left at the bedside for Resident #50. This had the potential to affect seven residents (#3, #24, #35, #37, #47, #84, and #88) who the facility identified as cognitively impaired and mobile. Facility census was 84. Findings include: 1. Observation on 07/15/26 at 7:39 A.M. of the first-floor medication cart serving residents in rooms 103 to 112 revealed the following: one unidentified small white round pill laying loosely in the bottom of the medication drawer. Interview at the time of observation with Licensed Practical Nurse (LPN) #203 confirmed the pill was laying loose in the bottom of the drawer. LPN #203 stated they could not identify what kind of pill it was. Observation on 07/15/26 at 8:08 A.M. of the first-floor medication cart serving residents in rooms 113-126 revealed the following: one unidentified round orange pill, one unidentified broken pink pill, one unidentified oblong white pill, one unidentified white round pill, and one unidentified pink and white oblong capsule. Further observation revealed two bottles of Iron 325/65 mg tablets with a best by date of 06/26. Interview at the time of observation with Registered Nurse (RN) #409 confirmed the loose pills in the medication drawers and the two bottles of expired pills. RN #409 confirmed they could not identify the loose pills. RN #409 stated they did not administer the expired Iron tablets to any residents that day. Observation on 07/15/26 at 8:17 A.M. of the second-floor medication cart serving residents in rooms 209A-226 revealed the following: one unidentified oblong white pill loose in drawer and one bottle of Guaifenesin (expectorant) 400 mg immediate release tablets with an expiration date of 12/2024. Further observation revealed the expired bottle of Guaifenesin was opened and labeled with an opening date of 06/26/26. Interview at the time of observation with LPN #255 confirmed the loose pill in the medication drawer and the expired bottle of medication. LPN #255 confirmed they were unable to identify the loose medication. LPN #255 confirmed they had not administered the expired Guaifenesin to any resident that day. Interview on 07/15/26 at 8:32 A.M. with the Director of Nursing #232 revealed the expectation is nurses should be checking the medication carts daily for expired medications and loose pills and the facility should be doing weekly audits of the medication carts to ensure proper storage of medications. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the medical record for Resident #50 revealed an admission date of 04/24/19. Diagnoses included unspecified dementia, anoxic brain injury, ataxia, vascular disease, epilepsy, schizoaffective disorder, Parkinson's disease, unspecified psychosis and dysphagia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #50 was cognitively impaired with a Brief Interview of Mental Status (BIMS) of 11. Review of the physician orders from admission through 07/20/26 revealed Resident #50 had no past or current orders for Bacitracin Zinc (topical antibiotic) ointment or Nystatin (antifungal) powder. Observation on 07/13/26 at 11:00 A.M. found a tube of Bacitracin Zinc ointment and a full container of Nystatin powder sitting on residents nightstand in his room. The Bacitracin Zinc ointment had no date and the Nystatin powder stated it was filled on 06/30/26. Interview on 07/13/26 at 11:12 A.M. with Licensed Practical Nurse (LPN) #299 confirmed Resident #50 had Bacitracin Zinc ointment (undated) and Nystatin powder (dated 06/30/26) unsecured and located on the bedside table. The LPN confirmed Resident #50 had no orders for either treatment medication in the electronic medical record. Review of the facility policy titled Medication Labeling and Storage dated 2001, revealed the facility shall store all medications and biologicals in locked compartments and only authorized personnel shall have access to keys. Medications and biologicals shall be stored in the packaging containers in which they were received from the issuing pharmacy and the nursing staff was responsible for maintaining medication storage and preparation areas in clean, safe, and sanitary manner. If medications are discontinued or outdated facility shall contact the dispensing pharmacy for instructions or shall destroy these items. This deficiency represents non-compliance investigated under Complaint Number 2799087.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility failed to complete an advance directive form in a timely manner for Resident #11. This affected one of one resident investigated for advanced directives. The facility census was 84. Findings include: Review of Resident #11's medical record revealed the resident was admitted [DATE] with intact cognition and had diagnoses that included fibromyalgia, chronic respiratory failure, and atherosclerotic heart disease. Review of Resident #11's physicians orders revealed the following active order revised on 01/12/26: Advanced directive Do not Resuscitate Comfort Care Assist (DNRCCA). Review of Resident #11's most recent care plan revealed the following focus area: Resident's code status is DNRCCA initiated 10/16/25. Review of Resident #11's DNR order form revealed the following sections completed: resident information, required signature of physician, Advanced Practice Registered Nurse (APRN) or Physician Assistant (PA), and name of supervising physician or collaborating physician. Review of the DNR order form revealed no date of physician signature and no box checked for which DNR type was ordered. Interview on 07/15/26 at 12:58 P.M. with the Administrator confirmed the DNR order form for Resident #11 was incomplete. The Administrator confirmed the DNR order form should be dated and one of the DNR choice boxes (DNRCC or DNRCCA) should be checked on the form. Review of the facility policy titled Advanced Directives revised September 2022 stated the resident has the right to formulate an advanced directive, including the right to accept or refuse medical or surgical treatment. Advanced directives are honored in accordance with state law and facility policy.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to ensure the resident representative was notified of a fall. This affected one resident (#93) of three residents reviewed for accidents. The facility census was 84. Findings include: Review of the medical record revealed Resident #93 was admitted to the facility on [DATE] and discharged on 01/30/26. Diagnoses included altered mental status, repeated falls, chronic obstructive pulmonary disease, and dementia. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #93 had moderately impaired cognition, and substantial assistance with toileting and bathing. Review of the progress note for Resident #93 dated 01/23/2026 at 2:10 P.M. revealed the nurse walked down hallway and patient was crouched down towards the floor, nurse went into patient's room and assisted patient to one knee. Patient was exhibiting agitation and confusion, nurse got other nurse to come assist in transferring patient back into bed. Patient was placed into bed, hospice was notified, fall mats were placed on both sides of patient's bed, bed was put in lowest position and checks on patient are being made more frequently. The Director of Nursing (DON) was notified, will continue to monitor. Interview on 07/16/26 at 8:17 A.M. with the Assistant Director of Nursing (ADON) #302 confirmed the resident representative for Resident #93 was not notified of the Resident #93 fall on 01/23/26. Interview on 07/20/26 at 9:46 A.M. with the Director of Nursing (DON) confirmed there was no documentation of the resident representative being notified of a fall on 01/23/26 for Resident #93. This deficiency represents non-compliance investigated under Complaint Number 2737390 and 2709514.		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure a resident was free from physical restraints. This affected one resident (#94) of three residents reviewed for restraints. The facility census was 84. Findings include: Review of the medical record revealed Resident #94 was admitted to the facility on [DATE] and discharged on 06/05/26. Diagnoses included alzheimer's disease with late onset, mood disorder, disorientation, and unspecified dementia. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #94 had severely impaired cognition, and required substantial assistance with bathing and toileting the assessment coded bed rails and alarms were utilized in the care of Resident #94. Review of the provider orders and care plan for Resident #94 revealed no orders or interventions for side rails. Interview on 07/15/26 at 8:09 A.M. with Certified Nursing Assistant (CNA) #242 revealed side rails were used for Resident #94 on a daily basis. Interview on 07/15/26 at 8:23 A.M. with CNA #244 revealed side rails were used for Resident #94 on a daily basis. Interview on 07/16/26 at 8:17 A.M. with Assistant Director of Nursing (ADON) #302 revealed she was not sure if side rails were used for Resident #94 but would think they would use side rails for Resident #94. Interview on 07/20/26 at 9:46 A.M. with the Director of Nursing (DON) confirmed siderails were not documented as utilized in Resident #94's medical record. Review of the policy titled, Physical Restraint Use, undated, revealed Residents have the right to be free from physical restraints. This deficiency represents non-compliance investigated under Complaint Number 2799087.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and policy review, the facility failed to report an allegation of resident to resident abuse to the state agency. This affected one resident (#56) of three residents reviewed for abuse. The facility census was 84. Findings include: Review of the medical record revealed Resident #56 was admitted to the facility on [DATE]. Diagnoses included spinal stenosis, psychotic disorder with delusions, visual hallucinations, and paroxysmal atrial fibrillation. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #56 was cognitively intact, and required partial assistance with toileting and bathing. Review of the progress notes for Resident #56 dated 1/7/2026 at 9:05 P.M. revealed this resident was in room and scooted bedside commode next to closet door picked her shoe up and was banging on the closet door with her shoe, when asked what was wrong the resident stated that her roommate has tried to kill her all day and hit and kicked her in the ribs resident was checked for injuries, resident has no red marks or bruises resident was redirected and reorientated, resident still says that her roommate is working for a company that is trying to get to her resident was reinsured that she is safe here and is now resting comfortably in bed. Interview on 07/13/2026 2:15 P.M. with Resident #56 revealed she was beat up in January 2026 by her roommate. Resident #56 stated her roommate was moved out the next day. Interview on 07/20/26 at 9:39 A.M. with the Administrator confirmed an investigation was not completed and not reported to the state agency for Resident #56's allegation of abuse in January 2026. Review of the policy titled, Abuse, dated 01/22/25, revealed possible indicators of abuse include, but are not limited to resident, staff or family report of abuse. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. The facility will have written procedures that include reporting of all alleged violations to the Administrator, state agency and to all other required agencies within specific timeframes.		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and policy review, the facility failed to ensure discharge planning was in place. This affected one resident (#56) of three residents reviewed for discharge. The facility census was 84. Findings include: Review of the medical record revealed Resident #56 was admitted to the facility on [DATE]. Diagnoses included spinal stenosis, psychotic disorder with delusions, visual hallucinations, and paroxysmal atrial fibrillation. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #56 was cognitively intact, and required partial assistance with toileting and bathing. Review of the Care Conference dated 04/07/26 for Resident #56 revealed the resident was short term with plans for discharge to an Assisted Living. Interview on 07/13/2026 at 2:15 PM with Resident #56 revealed Resident #56 could not recall the last care conference but wants to discharge and the social worker is not assisting with discharge plans. Interview on 07/15/26 at 12:59 P.M. with the Interim Social Service Director (SSD) #406 revealed there have been no updates or follow up to Resident #56's discharge plan since Resident #56's care conference held on 04/07/26 due to the previous Social Worker stopped working at the facility. Review of the policy titled, Discharge Planning, dated 07/28/25, revealed this facility is committed to ensuring that all resident discharges are conducted in a safe, person-centered, and compliant manner in accordance with CMS regulations. Discharges will be planned collaboratively with the resident, their representative, and the interdisciplinary team, with a focus on continuity of care, resident rights, and regulatory compliance. Update goals and services based on resident progress and needs.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on medical record review, staff interview and facility policy review, this facility failed to notify the ombudsman of resident discharge. This affected two residents (#2 and #92) of the three residents reviewed for discharge process. The facility census was 84. Findings include: 1. Review of the medical record for Resident #2 revealed an admission date of 04/03/2026 and a discharge date of 04/22/2026. Diagnosis included generalized anxiety, Thoracic (T) T11-T12 wedge compression fracture, and major depressive disorder. Review of nursing progress notes dated 04/15/2026 revealed Resident #2 was admitted to a local hospital and was set to discharge to another skilled nursing facility to be closer to family. Interview on 07/16/2026 at 10:39 A.M. with the Administrator confirmed the Ombudsman had not been notified of Resident #2's discharge from the facility as required. 2. Review of the medical record for Resident #92 revealed an admission date of 04/30/2026 and a discharge date of 05/04/2026. Diagnosis included dementia, emphysema, and atrial fibrillation. Review of a nursing progress note dated 05/04/2026 revealed Resident #92 was discharging home from the facility with family. Interview on 07/16/2026 at 10:39 A.M. with the Administrator confirmed the Ombudsman had not been notified of Resident #2's discharge from the facility as required. Review of facility provided documented titled Notification to Ombudsman of Resident Discharge, revised 07/23/2025 revealed that Nursing facilities are requires to notify the Office of the State Long-Term Care Ombudsman (SLTCO) of resident discharge. To complete the notification, the Ombudsman request facilities submit this completed form along with a copy of discharge notice to SLTCO.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of residents Pre-admission Screening and Resident Review (PASARR) assessment and facility policy review, this facility failed to ensure the appropriate, State-designated authority was notified of an individuals newly identified or diagnosed intellectual disability or mental disorder. This affected two residents (#4 and #7) of the three residents reviewed for appropriate PASARR assessments. The facility census was 84. Findings include: Review of Resident #4's medical record revealed the resident was admitted [DATE] and had diagnoses that included generalized anxiety disorder, depression, and bipolar disorder. Review of physician's orders revealed the following active orders: Mirtazapine (antidepressant) Oral Tablet 7.5 MG with a start date of 01/30/26 and Duloxetine HCL(antidepressant) Oral Capsule Delayed Release Sprinkle 30 MG with a start date of 01/31/26. Review of Resident #4's Preadmission Screening and Resident Review Identification Screen (PASRR) dated 01/08/26 revealed in Section E: Indications of Serious mental Illness Question 1: Does the individual have a diagnosis of any of the mental disorders below that only Panic or other Severe Anxiety Disorders is checked. No option is checked to reflect Resident #4's diagnosis of depression or bipolar disorder. Further review revealed in Section E Question 6: In the past six months has the individual been prescribed any psychotropic medications, the answer checked is No. Review of the PASRR revealed it does not document the antidepressants prescribed in the resident's orders. Review of the Preadmission Screening and Resident Review Result Notice dated 01/08/26 revealed the resident had no indications of serious mental illness and/or developmental disability. Interview on 07/16/26 at 1:46 P.M. with Licensed Social Worker (LSW) #406 confirmed that if a new mental health diagnosis is added to the resident's medical record and not reflected on the current PASRR, then a new PASRR should be completed. LSW #406 also confirmed a new PASRR should be completed if the resident has a new prescription for antidepressant medication not reflected on the current PASRR. LSW #406 confirmed Resident #4's PASRR was not completed accurately or updated with changes to her condition. Review of the facility policy titled PASRR dated 04/01/2023 revealed 1, Facilities will use QDM guidelines for PASRR for all new admissions and continued stays at facility.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and review of the medical record, the facility failed to ensure a care plan was in place for wandering for two residents (#35 and #47) and a care plan for toenail was in place for one resident (#81). This affected three Resident (#35, #47 and #81) of 24 reviewed for the initial sample. Facility census was 84. Findings include: 1. Review of the medical record for Resident #47 revealed an admission date of 06/20/26. Diagnoses included unspecified dementia with severe behaviors, diabetes, failure to thrive, and kidney disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #47 was cognitively impaired, with a BIMS of 4. Resident was also noted to be dependent with transfers and mobility and used a manual wheelchair. Review of the physician order dated 06/20/26 to 07/04/26 revealed an order for the resident to reside on the secure unit. Review of the dementia assessment dated [DATE] revealed resident was disoriented to time and place with her immediate memory intact. The resident was unable to recall most events, and had great resistance to care giving. Review progress notes dated 06/24/26 at 8:49 P.M. revealed the resident used a wheelchair. Review of the elopement assessment dated [DATE] revealed resident scored a one which meant she was at risk. The assessment indicated resident verbalized desire to go home or stayed near an exit door and documented the resident been recently admitted or re-admitted and was not accepting of the situation. Resident had no elopement assessments in the medical record after 07/01/26. Review of progress note dated 07/02/26 revealed resident's family was contacted and informed of the resident's room move due to facility need. Review of progress note dated 07/04/26 at 6:30 P.M. revealed the door alarm was activated when Resident #47 attempted to exit through the secured door. The resident appeared exit seeking and required staff redirection away from the exit. 15-minute checks were initiated. Review of the progress note dated 07/06/26 from an Interdisciplinary Team (IDT) fall note revealed resident was ambulatory with assist. Review of the progress note dated 07/06/26 at 5:26 P.M. revealed resident was attempting to get on the elevator. The nurse was able to redirect without incident and the on call nurse and nurse practitioner were made aware. Another note dated 07/06/26 revealed facility staff located resident on the floor next to her wheelchair by the doorway on her buttock with her back against the door. Review of progress notes dated 07/09/26 and 07/10/26 stated resident was monitored on 15 minute checks. Review of two progress notes dated 07/10/26, one entered as a late entry and a second entered at 9:30 P.M. revealed the resident had an elopement assessment and scored a one 1 solely on a documented history of exit seeking behaviors. Resident was assessed and was no longer demonstrating exit seeking behaviors. Review of the care plan on 07/15/26 revealed no mention of resident having a history of residing on a secured locked unit and no entry related to wandering or exit seeking behaviors. Interview on 07/09/26 at 10:26 A.M. with Registered Nurse #292 (RN) and Licensed Practical Nurse #413 (LPN) revealed Resident #47 wandered. They reported concern related to her being taken off a locked memory care unit to a non-locked area with no new interventions. They reported she had pressed on doors until they alarmed and had attempted to go down the elevator. They confirmed she was unable to state her intent and was unable to explain what she was doing or where she was going. Interview attempted on 07/13/26 at 2:10 P.M. with Resident #47 revealed resident was unable to respond to any questions and was providing non sensical answers, even to simple yes and no questions. Observation on 07/14/26 at 9:59 A.M. revealed Resident #47 was actively wandering on the unit. Observation and interview on 07/15/26 from 9:04 A.M. to 9:30 A.M. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed Resident #47 was being wheeled in her wheelchair down the hall by Certified Nursing Aide (CNA) #403. CNA reported the resident had wandered and was pushing on the exit doors. She reported frustration with residents being confused and unsecured with no new interventions to ensure their safety. Observation on 07/16/26 at 9:00 A.M. revealed Resident #47 was in her wheelchair and was moving around the unit without staff assistance. Resident was able to move her wheelchair by self propelling by her feet. The resident was going between the exit door and the dining area and was observed to push on the exit door causing the alarm to activate. Interview on 07/16/26 at 10:00 A.M. with MDS Coordinator #214 confirmed Resident #47's care plan included no mention of her wandering or exit seeking. 2. Review of the medical record for Resident #35 revealed an admission date of 06/09/25. Diagnoses included polyneuropathy, respiratory failure, hypoxia, Alzheimer's, dementia with behaviors, atrial fibrillation and heart disease. Review of the elopement assessment dated [DATE] revealed resident scored a four which meant he was at risk. The assessment indicated resident had a history of elopement or attempted elopement, had a history of attempting to leave without informing staff, verbalized desire to go home or stayed near an exit door, had wandering behavior that was aimless and non-goal directed. Review of progress notes dated 05/31/26 at 11:41 A.M. revealed resident was wheelchair bound at baseline. Review of the provider note dated 06/02/26 at 3:37 P.M. revealed the resident had Alzheimer's disease and wandering and exit seeking behavior. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #35 was cognitively impaired, with a BIMS of 00. Resident was also noted to be substantial maximum assist for mobility. Review of the behavior assessment dated [DATE] revealed resident had poor safety awareness and wandering and would benefit from a behavior unit. Review of the dementia assessment dated [DATE] revealed resident was unable to recall most recent events, had purposeful wandering, sleep disturbances and was unable to complete two-step instructions. Review of the elopement assessment dated [DATE] at 1:27 P.M. revealed resident scored a zero. The assessment indicated resident had no current or history of wandering or exit seeking behaviors. Review of the elopement assessment dated [DATE] at 6:03 P.M. revealed resident scored a zero. The assessment indicated resident had no current or history of wandering or exit seeking behaviors. Review of the progress note on 07/09/26 at 6:00 P.M. revealed an elopement assessment note that stated in last 90 days resident had exhibited none of these behaviors and had not attempted to exit the facility or verbalize a desire to go home. The interdisciplinary team discussed residents risk of elopement and found resident to be at no risk based in current actions and behaviors. Interview on 07/09/26 at 10:26 A.M. with Registered Nurse #292 (RN) and Licensed Practical Nurse #413 (LPN) revealed Resident #35 wandered. Observation on 07/14/26 at 10:05 A.M. revealed Resident #35 was actively wandering. Review of the care plan on 07/15/26 revealed no mention of resident's history of residing on a secured locked unit and no entry related to wandering or exit seeking behaviors. Observation on 07/15/26 at 8:40 A.M. revealed Resident #35 was observed pressing on exit door while sitting in his wheelchair. He was observed scooting back and forth from one end of the hall to the other most of the morning. Interview on 07/15/26 at 9:30 A.M. with Certified Nursing Aide (CNA) #403 confirmed Resident #35 was wandering pushing on the exit doors. She reported frustration with residents being confused and unsecured with no new interventions to keep them safe. She confirmed the facility had only closed a sliding glass door that was unlocked as an intervention. Interview on 07/16/26 at 12:35 P.M. with the Director of Nursing (DON) and a visiting DON #402 reviewed the care plan and confirmed it did not contain any language related to elopement or wandering. 3. Review of the medical record for Resident #81 revealed an admission date of 06/20/25. Diagnoses included unspecified dementia without behaviors, heart disease, kidney disease and weakness. Review of podiatry note dated (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/16/25 revealed the resident's nails were trimmed this date. The note recommended professional treatment and follow-up. Review of the plan of care dated 04/19/26 revealed resident had an activity of daily living self care performance deficit with interventions for finger nail care to check the length and trim and clean on bath day and as necessary. The care plan made no mention of toenails or podiatry services. Review progress notes dated 06/18/26 from the Nurse Practitioner revealed a recommendation for resident to see podiatry for toenail trimming. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #81 was cognitively impaired, the BIMS was not completed as resident was rarely if ever understood. The Resident was noted to be dependent with hygiene care. Observation and interview on 07/16/26 at 8:28 A.M. with Certified Nursing Aide (CNA) #290 revealed they removed Resident #81's socks to observe her toes. Residents toenails were over a half an inch past the nail bed. CNA #290 confirmed Resident #81's toenails were very long and reported all facility residents require podiatry to trim toenails. She revealed she was unsure if staff could trim toenails or not. Interview on 0/16/26 at 10:00 A.M. with MDS coordinator #214 confirmed the care plan did not mention toenails or podiatry care.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and policy review, the facility failed to ensure one resident (#3), of nine residents the facility identified as needing maximal assistance with eating, receive assistance with eating. Further, the facility failed to ensure toenail care was provided for one resident, (#81) of three residents reviewed for Activities of Daily Living (ADL). The facility census was 84. Findings include: Review of the medical record revealed Resident #3 was admitted to the facility on [DATE]. Diagnoses included cerebral infarction, dysphagia, dementia, chronic obstructive pulmonary disease, and cognitive communication deficit. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #3 had moderately impaired cognition, and required substantial assistance with toileting and bathing. Review of the provider orders for Resident #3 dated 02/18/26 revealed feeding restrictions, resident needs max assist feeding with each meal for nutrition. Review of the provider orders for Resident #3 dated 03/25/26 revealed feeding order, nurse to ensure that resident is fed by staff for all meals with meals for to ensure proper nutrition. Observation on 07/16/26 at 7:54 A.M. in Resident #3's room of Resident #3 lying in bed with bedside table placed across the bed with the breakfast tray on it, Resident #3 was holding the plate in his lap and spilling food on his blanket and lap. Interview and observation on 07/16/26 at 8:00 A.M. with Certified Nursing Assistant (CNA) #290 confirmed meal trays were being passed to resident rooms around 7:30 A.M. CNA #290 Resident #3's plate and fork was in Resident #3's lap with spilling food. Interview on 07/16/26 at 8:02 A.M. with CNA #407 confirmed CNA #407 passed Resident #3's tray around 7:30 A.M. and was not sure if he needed assistance with eating or not so CNA #407 confirmed the tray was set up for Resident #3 on his bedside table so Resident #3 could start eating while the trays were passed to the other residents. Interview on 07/16/26 at 8:05 A.M. with the Director of Nursing (DON) stated Resident #3 can feed himself but sometimes requires hands on or queuing. Interview on 07/16/26 at 8:17 A.M. with the Assistant Director of Nursing (ADON) #302 confirmed Resident #3 needs to be fed for all meals. The ADON #302 confirmed the order for Resident #3 to be fed for all meals. Interview on 07/20/26 at 9:46 A.M. with the DON confirmed the order for max assist for all meals for Resident #3 and staff need to be with Resident #3 to provide max assist with meals. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled, Activities of Daily Living (ADL), Supporting, dated 2001, revealed residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident in accordance with the plan of care, including appropriate support and assistance with dining. 2. Review of the medical record for Resident #81 revealed an admission date of 06/20/25. Diagnoses included unspecified dementia without behaviors, heart disease, kidney disease and weakness. Review of podiatry note dated 06/16/25 revealed the resident's nails were trimmed this date. The note recommended professional treatment and follow-up. Review of the plan of care dated 04/19/26 revealed resident had an activity of daily living self care performance deficit with interventions for finger nail care to check the length and trim and clean on bath day and as necessary. The care plan made no mention of toenails or podiatry services. Review progress notes dated 06/18/26 from the Nurse Practitioner revealed a recommendation for resident to see podiatry for toenail trimming. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #81 was cognitively impaired, and the Brief Interview of Mental Status (BIMS) was not completed as resident was rarely if ever understood. The Resident was noted to be dependent with hygiene care. Observation and interview on 07/16/26 at 8:28 A.M. with Certified Nursing Aide (CNA) #290 revealed they removed Resident #81's socks to observe her toes. Residents toenails were over a half an inch past the nail bed. CNA #290 confirmed Resident #81's toenails were very long and reported all facility residents require podiatry to trim toenails. She revealed she was unsure if staff could trim toenails or not. Interviews on 0/16/26 at 10:00 A.M. and 10:10 A.M. with MDS coordinator #214 confirmed the staff should be able to trim toenails but would need to double check. A second interview confirmed the aides were not trained to complete any nail care and nursing should be trimming toenails and monitoring if the need trimmed by podiatry. Interview on 01/16/26 at 10:30 A.M. with the Administrator confirmed the last podiatry visit was 06/2025 and confirmed staff was unable to locate any notes in the past year. Review of facility policy titled, Activities of Daily Living dated 03/2018 revealed residents shall be provided with care treatment and services as appropriate. Residents who were unable to carry out activities of daily living shall received services to maintain good hygiene care. Review of facility policy titled, Clinical Services-Podiatry dated 07/01/26 revealed residents should have access to podiatry care and services and should have documented nots and treatments in the medical record. (continued on next page)		

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Numbers 2726588, 3073628, 2684291, 2983546, 2709514 and 2686126.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, review of the medical record, and review of the facility policy, facility failed to ensure timely communication and care for a resident receiving hospice services. This affected one resident (#35) of one reviewed for hospice services. Facility census was 84. Findings include: Review of the medical record for Resident #35 revealed an admission date of 06/09/25. Diagnoses included polyneuropathy, respiratory failure, hypoxia, Alzheimer's, dementia with behaviors, atrial fibrillation and heart disease. Review of the care plan dated 02/20/26 revealed resident was at risk of developing clinically unavoidable declines secondary to having a terminal prognosis of Alzheimer's disease for which the resident received hospice services. The interventions included follow the hospice plan of care and notify hospice for any changes in condition or significant declines and work cooperatively with the hospice team. Review of the Physician order dated 06/05/26 revealed an order a right arm and hand X-ray including humerus, forearm and hand for pain and decreased mobility. Review facility progress notes from 05/31/26 through 06/07/26 revealed a note dated 05/31/26 revealed the resident was found by staff on the floor in his room and sustained an injury of bleeding to the right elbow and a skin tear to the right hand finger. Progress note dated 06/01/26 revealed the resident had a bruise/hematoma and skin tear to the right elbow and bruising to the back of the hand. Note dated 06/01/26 revealed hospice and family were notified of the fall. Progress note dated 06/02/26 revealed resident had bruising to the right hand. Review of the progress note dated 06/02/26 revealed Resident #35's daughter voiced concern about resident's right hand which was injured during the fall. The note stated resident had significant bruising and edema and the resident was unable to follow commands for an assessment due to a Brief Interview of Mental Status (BIMS) of 00. The residents daughter was requesting an X-ray and had questions about splinting his hand. The nurse reported she would contact hospice regarding her concerns. The nurse checked in with hospice and they stated a nurse would be onsite to evaluate and another note after the hospice visit stating no new orders were given by hospice. Note dated 06/03/26 revealed resident had a bruise/hematoma and edema to the right hand. Note dated 06/05/26 revealed the staff spoke with hospice about an X-ray for the right hand. The nurse informed hospice resident was expressing pain by withdrawing from touch, facial grimacing and groaning out in pain. The hospice stated they would call back about doing the X-ray. A second note dated 06/05/26 stated staff were awaiting hospice sending a fax with the new X-ray order. Note dated 06/06/26 and revealed the residents daughter voiced a desire to have an X-ray of the right hand. The daughter was instructed by this nurse to contact hospice directly as they are his primary provider. The family contacted hospice and the X-ray was ordered. Note dated 06/07/26 revealed the X-ray results were obtained and found resident had a complete fracture through the base of the proximal phalanx of the fourth digit on the right hand. Staff also spoke with hospice and they ordered a splint. Review of hospice progress note dated 06/06/26 revealed the hospice nurse came and assessed the resident and an X-ray was ordered for the right upper extremity and identified a fracture of the finger. The note reported the nurse had informed the facility of their responsibilities with care and communication with hospice team after a delay in getting an X-ray for the resident. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #35 was cognitively impaired, with a Brief Interview of Mental Status (BIMS) of 00. Resident was also noted to be substantial maximum assist for mobility. Review of the hospice contract dated 01/03/24 revealed hospice was responsible for managing the terminal diagnosis and the facility was responsible for all other care. Interview on 07/15/26 at 9:13 A.M. with Licensed Practical Nurse (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(LPN) #255 revealed she was working when Resident #35's daughter asked about getting an X-ray of his hand. The LPN #255 reported resident's hand was bruised and swollen. The LPN #255 revealed she reached out to hospice and they were planning to send a nurse out for an assessment. She also reported she was working a few days later when the family asked again about an X-ray and reported she contacted the facility medical provider and was instructed to have family reach out directly to hospice for an X-ray order as they were the primary provider for resident. She also revealed resident was visibly in pain and was administered as needed pain meds. Interview on 07/15/26 4:10 P.M. with Hospice Executive Director ([NAME]) #417 confirmed they were the provider for Resident #35. She also acknowledged from the hospice note on 06/06/26 visit where the hospice nurse educated facility staff about the contract/agreement and about hospice and facility responsibilities. She confirmed facility could have ordered the X-ray and also confirmed if the facility had concerns they need to make those known as hospice can only order the X-ray if they assess and find a reason. Review of facility policy titled Hospice Program, dated 07/2017 revealed responsibilities of hospice included providing medical management of the terminal illness and the responsibilities of the facility included communicating with the hospice provider.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and review of the medical record, the facility failed to ensure residents were properly assessed and interventions were put in place when residents were moved from the secured memory care unit to an unsecured unit. This affected three Resident (#35, #47 and #81) of three reviewed for elopement risk. Facility census was 84. Findings include 1. Review of the medical record for Resident #47 revealed an admission date of 06/20/26. Diagnoses included unspecified dementia with severe behaviors, diabetes, failure to thrive, and kidney disease. Review of the Physician order dated 06/20/26 to 07/04/26 revealed an order for the resident to reside on the secure unit. Review of the dementia assessment dated [DATE] revealed resident was disoriented to time and place with her immediate memory intact. The resident was unable to recall most events, receptiveness and had great resistance to care giving. Review of facility progress notes for Resident #47 from 06/24/26 through 07/10/26 revealed a note dated 06/24/26 at 8:49 P.M. that documented the resident used a wheelchair. Review of progress note dated 07/01/26 at 4:19 P.M. revealed resident's family was contacted and informed her of the resident's room move due to facility need. Review of note dated 07/04/26 revealed the door alarm was activated when Resident #47 attempted to exit through the secured door. The resident appeared exit seeking and required staff redirection away from the exit. 15-minute checks were initiated. The progress note dated 07/06/26 at 3:17 P.M. from an Interdisciplinary team (IDT) fall note revealed resident was ambulatory with assist. Review of the progress note dated 07/06/26 at 5:26 P.M. revealed resident was attempting to get on the elevator. The nurse was able to redirect without incident and the on call nurse and nurse practitioner were made aware. Another note dated 07/06/26 at 5:58 P.M. revealed facility staff located resident on the floor next to her wheelchair by the doorway on her buttock with her back against the door. Notes dated 07/09/26 and 07/10/26 stated resident was monitored on 15 minute checks. Review of two progress notes dated 07/10/26, one entered as a late entry at 5:48 P.M. and a second entered at 9:30 P.M. revealed resident had an elopement assessment and scored a one 1 solely on a documented history of exit seeking behaviors. Resident was assessed and was no longer demonstrating exit seeking behaviors. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #47 was cognitively impaired, with a Brief Interview of Mental status (BIMS) score of 4. Resident was also noted to be dependent with transfers and mobility and used a manual wheelchair. Review of the elopement assessment dated [DATE] revealed resident scored a one which meant she was at risk. The assessment indicated resident verbalized desire to go home or stayed near an exit door and had been recently admitted or re-admitted and was not accepting of the situation. Resident had no elopement assessments in the medical record after 07/01/26. Review of the care plan on 07/15/26 revealed no mention of resident's history of residing on a locked, secured unit and then being moved to an unsecured unit. There also was no entry related to wandering or exit seeking behaviors. Interview on 07/09/26 at 10:26 A.M. with Registered Nurse #292 (RN) and Licensed Practical Nurse #413 (LPN) revealed Resident #47 wandered. They reported concern related to her being taken off a locked memory care unit to a non-locked area with no new interventions. They reported she had pressed on doors until they alarmed and had attempted to go down the elevator. They confirmed she was unable to state her intent and was unable to explain what she was doing or where she was going. Interview on 07/09/26 at 1:20 P.M. with the Director of Nursing (DON) revealed facility completed elopement assessments on residents before they were removed from the locked (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	memory care unit and placed on the unsecured unit. The medical record and assessments were reviewed and she was unable to explain without a change in the risk assessments, why Resident #47 was moved to an unsecured unit. The DON revealed she was unaware Resident #47 was still assessed to be at risk for elopement and was unaware of any interventions put in place when residents moved on 07/02/26 to ensure safety. Interview on 07/09/26 at 2:32 P.M. with Physician #500 revealed he was aware of the need to move residents. He revealed he would expect the staff to properly assess all the residents and determine needs for a safe transfer and ensure proper interventions were in place to ensure the safety of all the residents as they all have memory deficits. He confirmed he was not aware of residents on the non-locked areas having wandering behaviors. Interview on 07/09/26 at 2:59 P.M. with the DON confirmed Resident #47 did not exit seek when she was on the secured unit due to being in a wheelchair she would be unable to wander and move. The DON reported she was unaware of the notes and staff statements that the residents had been exit seeking and wandering. She also confirmed facility had no documentation of updated assessments and decision-making to move a resident off the secured memory care unit to an unsecured area and what interventions were needed. Interview on 07/09/26 at 4:00 P.M. with Regional Support #404 revealed the team assessed and discussed each resident and confirmed none of the updated information was documented in the medical record including discussions and interventions. She confirmed Resident #47 was in a tilt in space chair that would limit some mobility but acknowledged notes stating she had wandering attempts. She also confirmed a resident who used a wheelchair was not a disqualifier for needing a secured unit or interventions in place for safety from wandering. Interview attempted on 07/13/26 at 2:10 P.M. with Resident #47 revealed resident was unable to respond to any questions and was providing non sensical answers, even to simple yes and no questions. Observation on 07/14/26 at 9:59 A.M. revealed Resident #47 was actively wandering. Observation and interview on 07/15/26 from 9:04 A.M. to 9:30 A.M. revealed Resident #47 was being wheeled in her wheelchair down the hall by Certified Nursing Aide (CNA) #403. CNA reported the resident had wandered and was pushing on the exit doors. She reported frustration with residents being confused an unsecured with no new interventions to ensure their safety. Observation on 07/16/26 at 9:00 A.M. revealed Resident #47 was in her wheelchair and was moving around the unit without staff assistance. Resident was able to move her wheelchair by self propelling by her feet. The resident was going between the exit door and the dining area and was observed to push on the exit door causing the alarm to activate. 2. Review of the medical record for Resident #35 revealed an admission date of 06/09/25. Diagnoses included polyneuropathy, respiratory failure, hypoxia, Alzheimer's, dementia with behaviors, atrial fibrillation and heart disease. Review of the elopement assessment dated [DATE] revealed resident scored a four, which meant he was at risk. The assessment indicated resident had a history of elopement or attempted elopement, had a history of attempting to leave without informing staff, verbalized desire to go home or stayed near an exit door, had wandering behavior that was aimless and non-goal directed. Review of progress notes dated 05/31/26 through 07/09/26 revealed a note dated 05/31/26 resident was wheelchair bound at baseline. Provider note dated 06/02/26 at 3:37 P.M. revealed the resident had Alzheimer's disease and wandering and exit seeking behavior. Review of the progress note on 07/09/26 revealed an elopement assessment note that stated in last 90 days resident had exhibited none of these behaviors and had not attempted to exit the facility or verbalize a desire to go home. The interdisciplinary team discussed residents risk of elopement and found resident to be at no risk based in current actions and behaviors. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #35 was cognitively impaired, with a BIMS of 00. Resident was also noted to require substantial maximum (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assist for mobility. Review of the behavior assessment dated [DATE] revealed resident had poor safety awareness and wandering and would benefit from a behavior unit. Review of the dementia assessment dated [DATE] revealed resident was unable to recall most recent events, had purposeful wandering, sleep disturbances and was unable to complete two-step instructions. Review of the elopement assessment dated [DATE] revealed resident scored a zero. The assessment indicated resident had no current or history of wandering or exit seeking behaviors. Review of the elopement assessment dated [DATE] revealed resident scored a zero. The assessment indicated resident had no current or history of wandering or exit seeking behaviors. Review of the care plan on 07/15/26 revealed no mention of the resident's history of being on a locked, secured unit and moving to an unsecured unit nor did the care plan document wandering or exit seeking behaviors. Interview on 07/09/26 at 10:26 A.M. with Registered Nurse #292 (RN) and Licensed Practical Nurse #413 (LPN) revealed Resident #35 wandered. They reported concern related to him being taken off a locked memory care unit to a non-locked area with no new interventions. They reported he had pressed on doors until they alarmed. They confirmed he was unable to state his intent and was unable to explain what he was doing or where he was going. Interview on 07/09/26 at 1:20 P.M. with the Director of Nursing (DON) revealed facility completed elopement assessments on residents before they were removed from the locked memory care unit and placed on the unsecured unit. The medical record and assessments were reviewed and she was unable to explain about the change in the risk assessments from a score of four to a score of zero. The DON revealed she was unaware Resident #35 was still wandering and was unaware of any interventions put in place when residents moved on 07/02/26 to ensure safety. Interview on 07/09/26 at 2:32 P.M. with Physician #500 revealed he was aware of the need to move residents. He revealed he would expect the staff to properly assess all the residents and determine needs for a safe transfer and ensure proper interventions were in place to ensure the safety of all the residents as they all have memory deficits. He confirmed he was not aware of residents on the non-locked areas having wandering behaviors. Interview on 07/09/26 at 2:59 P.M. with the DON reported Resident #35 did not wander and reported she was not aware of staff reports of wandering. She also confirmed facility had no documentation of the decision-making to move a resident off the secured memory care unit to an unsecured area and what interventions were needed. Interview on 07/09/26 at 4:00 P.M. with Regional Support #404 revealed the team assessed and discussed each resident and confirmed none of the updated information was documented in the medical record including discussions and interventions. Interview attempted on 07/13/26 at 2:40 P.M. with Resident #35 revealed resident was unable to respond to any questions and was provided non-sensical answers, even to simple yes and no questions. Observation on 07/14/26 at 10:05 A.M. revealed Resident #35 was actively wandering. Observation on 07/15/26 at 8:40 A.M. revealed Resident #35 was observed pressing on exit door while sitting in his wheelchair. He was seen scooting back and forth from one end of the hall to the other most of the morning. Interview on 07/15/26 at 9:30 A.M. with Certified Nursing Aide (CNA) #403 confirmed Resident #35 was wandering pushing on the exit doors. She reported frustration with residents being confused and on an unsecured with no new interventions to keep them safe. She confirmed the facility had only closed a sliding glass door that was unlocked as an intervention. 3. Review of the medical record for Resident #81 revealed an admission date of 06/20/25. Diagnoses included unspecified dementia without behaviors, heart disease, kidney disease and weakness. Review of the physician order dated 06/21/25 to 07/04/26 revealed an order for the resident to reside on the secure unit. Review progress notes dated 06/18/26 from the Nurse Practitioner revealed resident was an elopement risk. The note stated she was mobile with use of her walker. Note dated 07/01/26 revealed the family was contacted to inform (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	them of a room move due to facility needs. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #81 was cognitively impaired, the BIMS was not completed as resident was rarely if ever understood. Review of the behavior assessment dated [DATE] revealed resident had poor safety awareness and wandering behavior. Review of the dementia assessment dated [DATE] revealed resident was unable to recall most events, had purposeless wandering and was unable to complete two step instructions. The assessment also stated resident was only able to speak one word and was unable to feed herself or complete simple tasks. The assessment revealed resident scored a seven for very severe cognitive decline and late dementia. Review of the elopement assessment dated [DATE] revealed resident scored a one which meant she was at risk. The assessment indicated resident verbalized desire to go home or stayed near an exit door and wandered. It stated the resident wandered aimlessly or non-goal directed. Observations on 07/09/26 at 10:45 A.M. revealed resident remained in her room and was not observed outside of her room. Interview on 07/09/26 at 1:20 P.M. with the Director of Nursing (DON) revealed facility completed elopement assessments on residents before they were removed from the locked memory care unit and placed on the unsecured unit. The medical record and assessments were reviewed and she was unable to explain without a change in the risk assessments, why Resident #81 was moved to an unsecured unit. The DON revealed she was unaware Resident #81 was still assessed to be at risk for elopement and was unaware of any interventions put in place when residents moved to an unsecured area on 07/02/26 to ensure safety. Interview on 07/09/26 at 2:32 P.M. with Physician #500 revealed he was aware of the need to move residents. He revealed he would expect the staff to properly assess all the residents and determine needs for a safe transfer and ensure proper interventions were in place to ensure the safety of all the residents as they all have memory deficits. He confirmed he was not aware of residents on the non-locked areas having wondering behaviors. Interview on 07/09/26 at 2:59 P.M. with the DON confirmed Resident #81 did not exit seek and was dependent with activities of daily living. She also acknowledged notes in the record stating she was a one-person assist and had been wandering. The DON reported she was unaware of these notes and documentation in the medical record. She also confirmed facility had no documentation of updated assessments or decision-making to move a resident off the secured memory care unit to an unsecured area and what interventions were needed. Interview on 07/09/26 at 4:00 P.M. with Regional Support #404 revealed the team assessed and discussed each resident and confirmed none of the updated information was documented in the medical record including discussions and interventions. Observations on 07/13/26 at 2:10 P.M. and 07/14/26 at 11:00 A.M. revealed resident remained in her room and was not observed outside of her room. This deficiency represents non-compliance investigated under Complaint Number 3073628.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365597	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/20/2026
NAME OF PROVIDER OR SUPPLIER Westmoreland Place		STREET ADDRESS, CITY, STATE, ZIP CODE 230 Cherry St Chillicothe, OH 45601	
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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility failed to ensure a medication error rate of less than five percent. This affected two of six residents observed for medication administration (Resident #62 and #72). The facility census was 84. Findings include: Observation of medication pass at the facility on 07/15/26 and 07/16/26 revealed 30 opportunities were observed with two errors being made by facility staff. The total medication error rate was 6.67 %. 1. Review of Resident #62's medical record revealed the resident was admitted on [DATE] and had diagnoses that included chronic obstructive pulmonary disease (COPD), chronic diastolic heart failure, and acute kidney failure. Review of the medical record revealed intact cognition. Observation on 07/16/26 at 8:09 A.M. with Registered Nurse (RN) #408 revealed the nurse preparing Resident #62's Fluticasone Salmeterol Aerosol Inhalation (corticosteroid) Inhaler for administration. Observation revealed RN #408 hand the inhaler to Resident #62. Resident #62 proceeded to inhale two puffs of the inhaler and then give the inhaler back to RN #408. Interview with RN #408 at the time of the observation confirmed the physician's order for the inhaler was for one puff inhaled orally. RN #408 stated that she did not notice that Resident #62 took two puffs of the inhaler during the medication administration. Review of Resident #62's physician's orders revealed the following active order with a start date of 04/03/26: Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated 500-50 MCG/ACT (Fluticasone-Salmeterol) 1 puff inhale orally every 12 hours for COPD. Review of the policy titled Administering Medications revised April 2019 revealed medications are administered in accordance with prescriber's orders, including any required time frame. 2. Review of Resident #72's medical record revealed the resident was admitted [DATE] and had diagnoses that included Type II Diabetes Mellitus, respiratory failure, and chronic kidney disease. Review of the medical record revealed intact cognition. Observation on 07/15/26 at 7:32 A.M. with Licensed Practical Nurse (LPN) #203 revealed the LPN put one 20 mg Omeprazole (proton pump inhibitor) Oral Capsule Delayed Release in a medicine cup with multiple other prescribed pills for Resident #72. The LPN preceded to crush all medications together and put the crushed mixture into a small cup of applesauce. The LPN then administered all crushed medications to resident. Interview with LPN #203 at time of medication administration confirmed that delayed release omeprazole was crushed and administered to the resident. LPN #203 stated that the resident took their medication crushed every day and tolerated the crushed medications well. Review of Resident #72's physician's orders revealed the following active order with a start dated of 11/03/24: Omeprazole Oral Capsule Delayed Release 20 MG. Review of Specialty RX (pharmcay) Do Not Crush Drug Guide (undated) revealed the drugs listed should not be chewed or crushed; they should be swallowed whole. Further review of the drug guide revealed Omeprazole cap/tab was on the do not crush list. Review of facility policy titled Crushing Medications revised 04/2018 revealed the nursing staff and/or consultant pharmacist shall notify any attending physician who gives an order to crush a drug that the manufacturer states should not be crushed (for example, long acting or enteric coated medications.) This deficiency represents non-compliance investigated under Complaint Number 2799087.		

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NAME OF PROVIDER OR SUPPLIER Westmoreland Place		STREET ADDRESS, CITY, STATE, ZIP CODE 230 Cherry St Chillicothe, OH 45601	
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility failed to ensure Resident #72 was free from significant medication errors. This affected one of six residents observed for medication administration. The facility census was 84. Findings include: Review of Resident #72's medical record revealed the resident was admitted [DATE] and had diagnoses that included Type II Diabetes Mellitus, respiratory failure, and chronic kidney disease. Review of the medical record revealed intact cognition. Observation on 07/15/26 at 7:32 A.M. with Licensed Practical Nurse (LPN) #203 revealed the LPN put one 20 mg Omeprazole (proton pump inhibitor) Oral Capsule Delayed Release in a medicine cup with multiple other prescribed pills for Resident #72. The LPN preceded to crush all medications together and put the crushed mixture into a small cup of applesauce. The LPN then administered all crushed medications to resident. Interview with LPN #203 at time of medication administration confirmed that delayed release omeprazole was crushed and administered to the resident. LPN #203 stated that the resident took their medication crushed every day and tolerated the crushed medications well. Review of Resident #72's physician's orders revealed the following active order with a start dated of 11/03/24: Omeprazole Oral Capsule Delayed Release 20 MG. Review of Specialty RX (pharmacy) Do Not Crush Drug Guide (undated) revealed the drugs listed should not be chewed or crushed; they should be swallowed whole. Further review of the drug guide revealed omeprazole cap/tab was on the do not crush list. Review of facility policy titled Crushing Medications revised 04/2018 revealed the nursing staff and/or consultant pharmacist shall notify any attending physician who gives an order to crush a drug that the manufacturer states should not be crushed (for example, long acting or enteric coated medications.)		

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NAME OF PROVIDER OR SUPPLIER Westmoreland Place		STREET ADDRESS, CITY, STATE, ZIP CODE 230 Cherry St Chillicothe, OH 45601	
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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility failed to ensure routine dental services were provided for Resident #11. This affected one of two residents investigated for dental concerns. The facility census was 84. Findings include: Review of Resident #11's medical record revealed the resident was admitted [DATE] with intact cognition and had diagnoses that included fibromyalgia, chronic respiratory failure, obstructive sleep apnea, and atherosclerotic heart disease. Review of Resident #11's physician's orders revealed the following active order with a start date of 01/10/26: Audiologist, Podiatrist, Dentist, Optometrist, Psychiatrist may consult and treat PRN. Review of Resident #11's progress notes revealed the following progress note dated 12/10/25 at 6:32 P.M. social worker (SW) made aware that resident needs dentist appointment. Further review of progress notes from 12/10/25 to 07/16/26 revealed no mention of a dentist's appointment being scheduled for or attended by Resident #11. Review of all facility dental notes for the last six months revealed no dentist appointment notes for Resident #11. Interview on 07/16/26 at 12:46 P.M. with Licensed Social Worker #406 confirmed Resident #11 was not seen by a dentist since the social worker was made aware of the need for an appointment on 12/10/25. Review of facility policy titled Dental Services revised 12/16 revealed routine and 24-hour emergency dental services are provided to the residents through a contract agreement with a licensed dentist that comes to the facility monthly, referral to the resident's personal dentist, referral to the community dentists, or referral to other health care organizations that provide dental services.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 record review, interviews, and review of the facility policy, the facility failed to ensure the residents' medical record was maintained in an accurate manner. This affected one residents (#69) of 24 Resident records reviewed in the initial pool. Facility census was 84. Findings include: Review of the medical record for Resident #69 revealed an admission date of 05/11/26. Diagnoses included cervical disc disorder, diabetes, kidney disease, spinal stenosis, and heart failure. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #69 was cognitively impaired, with a BIMS of 00. Resident was also noted resident required supervision/touching assistance for mobility and transfers. Review of the fall investigation dated 05/30/26 revealed the fall occurred at 3:45 A.M. when resident fell in the bathroom. He suffered bruise to his scalp and the physician was notified on 05/30/26 at 4:32 A.M. Review of the neurological checks completed stated that they began 05/30/26 at 3:40 A.M. Review of the progress note dated 05/30/26 revealed the facility staff found resident on the ground in the bathroom and revealed the Assistant DON and Nurse Practitioner were notified. Review of the fall investigation dated 06/03/26 revealed the fall occurred at 6:45 A.M. when resident fell in his room. He suffered a nose bleed and the physician was notified on 06/03/26 at 6:32 A.M. Review of the neurological checks completed stated that they began 06/03/26 at 6:00 A.M. Review of the progress note dated 06/03/26 revealed the facility staff found resident on the ground in the bedroom and suffered a bloody nose. Interviews on 07/16/26 from 12:10 P.M. to 2:20 P.M. with the Director of Nursing (DON) and a visiting DON #402 confirmed the fall investigations had inaccurate documentation. They confirmed it was not possible for the physician to be notified prior to a fall and for neurological checks to begin prior to a fall. They acknowledged an inaccurate timeline of events related to fall for Resident #69. Review of the facility policy titled, Charting and Documentation dated 07/2017 revealed documentation in the medical record shall be objective, complete and accurate.		