STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365617	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Ayden Healthcare of Waterville		STREET ADDRESS, CITY, STATE, ZIP CODE 8885 Browning Drive Waterville, OH 43566	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and facility policy review, the facility failed to ensure foods were prepared and stored in a safe manner to prevent spoilage and contamination and failed to maintain the kitchen environment in a sanitary manner. This had the potential to affect all 72 residents who received food from the kitchen. The facility identified four (#1, #44, #50, and #74) residents who received no food by mouth and no food from the kitchen. The facility census was 76.Findings include:Observation on 03/16/26 at 8:10 A.M. of the kitchen found significant dust build up on the ceiling vent and on the ceiling surrounding the vent over the coffee area, juice dispenser, toaster and preparation area.Observation on 03/16/26 at 8:16 A.M. of the walk-in cooler found a box of multiple cartons of liquid eggs being stored on the floor.Interview on 03/16/26 at 8:18 A.M. with Dietary Supervisor (DS) #698 verified the box of eggs were being stored on the floor of the walk-in cooler. DS #698 reported deliveries were received on Tuesdays and Fridays and it was noted to be Monday. Observation on 03/16/26 at 8:20 A.M. of the dry storage room found two large bags of pasta opened, undated, and on the dry storage shelf. One bag of pasta was open to air. Coinciding interview with DS #698 verified the pasta was open and undated and the one bag was open to air. The open to air pasta was removed from use. Observation on 03/16/26 at 8:26 A.M. of the ceiling vents over the clean dish end of the dishwasher in the dish room and ceiling vents over the clean plate stack for meal service in the steam table and cooking area of the kitchen found significant dust build up. Additionally, the wall above the steam oven and the wall along the meal tray line near the clean plates for meal services had significant dust build up.Interview on 03/16/26 at 8:27 A.M. with DS #698 verified the significant dust build up on the vents, ceilings, and walls in the dish room and kitchen preparation and serving area. Observation on 03/16/26 at 8:29 A.M revealed DS #698 was cooking ground beef on the stove. DS #698 was observed not wearing a hair net. Coinciding interview with DS #698 verified she had not been wearing a hairnet and stated it must have fallen off. DS #698 replaced her hair net. Observation on 03/16/26 at 8:32 A.M. of the reach-in cooler found one cup of cottage cheese and six small cups of what appeared to be ranch salad dressing undated and unlabeled. Coinciding interview with DS #698 verified the cups were undated and they were disposed of. Observation on 03/16/26 8:35 A.M. of the reach-in freezer found an opened cup of ice cream on the shelf with the lid not covering the entirety of the ice cream. Coinciding interview with DS #698 verified the ice cream should not have been open in the freezer and the ice cream was discarded. Review of the facility policy titled, Employee Sanitary Food Practices, revised 03/07/21, revealed all employees would wear hair restraints including hair net and or a beard restraint. Review of the facility policy titled, Food Storage, revised 03/07/21, revealed dry storage foods should be dated and the label should be visible. Plastic containers with tight fitting covers must be used for storing grain products, sugar, dried vegetables, and broken lots of bulk food. Refrigerated food should be covered, labeled, and dated. All foods will be stored off the floor. Frozen foods should be covered, labeled, and dated.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, review of the facility water management plan, review of facility policies, and review of the Centers for Disease Control and Prevention (CDC) Legionella control guidance, the facility failed to ensure measures to prevent the growth of Legionella were implemented, failed to ensure urinary catheter drainage bags were maintained in a manner to prevent infection, failed to ensure appropriate personal protective equipment was worn during high-contact care interactions for residents on enhanced barrier precautions, and failed to ensure appropriate hand hygiene was maintained and performed during resident interactions involving potential exposure to bodily fluids. This deficient practice had the potential to affect all 76 residents residing in the facility. The census was 76. Findings include: 1. Review of the facility risk management plan for Legionella control revealed that control of Legionella would involve the on-going review and removal of long plumbing runs and/or dead ends. Further review revealed where it was not practical, the facility would follow its policy of regular flushing of the system. Furthermore, the control plan recommended storing water above 140 degrees Fahrenheit (F) to continuously kill the Legionella bacteria. Review of facility vacant room water flush logs revealed the last documented flush was on 03/12/24. No documentation of water temperature logs were provided. Interview on 03/19/26 at 11:28 A.M. with Director of Maintenance (DM) #686 revealed the facility was not recording water temperatures. Additionally, the DM #686 confirmed that, although the facility was flushing water in unused areas of the facility, they were not tracking or logging the flushes. Review of the Centers for Disease Control and Prevention (CDC) plan for legionella control titled, Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings, dated 06/24/25, revealed there are seven steps to an effective water management program including establishing a water management program team, describing the building water systems using text and flow diagrams, identifying areas where Legionella could grow and spread, deciding where control measures should be applied and how to monitor them, establishing ways to intervene when control limits are not met, making sure the program was running as designed and was effective, and documenting and communicating all the activities. 2. Review of the medical record revealed Resident #13 was admitted to the facility on [DATE]. Diagnoses included morbid obesity, neuromuscular dysfunction of the bladder, and fracture of an unspecified part of the neck of the right femur. Review of Minimum Data Set (MDS) assessment dated [DATE] for Resident #13 revealed the resident was cognitively intact. Resident #13 was dependent on staff for all activities of daily living (ADLs). Review of the care plan dated 03/11/26 for Resident #13 revealed the resident was at risk for alteration in elimination related to being occasionally incontinent of bowel and had an indwelling urinary (Foley) catheter. Goals include the resident would be free from complications related to appliance/catheter use. Interventions included catheter care every shift, change Foley catheter as needed, empty Foley catheter bag every shift and as needed, and Foley catheter to straight drain. Observation on 03/16/26 at 8:41 A.M. revealed Resident #13 had a urinary catheter bag that was (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	laying on the floor and up against the bottom bedrail while the bed was in a low position. Interview on 03/16/26 at 8:41 A.M. with Certified Nurse Aide (CNA) #623 confirmed Resident #13's urinary catheter bag was on the floor. Furthermore, CNA #623 revealed when Resident #13's bed was in the lowest position the bag would rest on the floor and the staff could not figure out where to hang the bag to avoid contact with the floor. Review of facility policy titled, Catheter Care, Urinary, revised 09/2014, revealed infection control measures for residents with indwelling urinary catheters included catheter tubing and drainage bag are to be kept off the floor. 3. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE]. Diagnoses included unspecified head injury, type II diabetes, moderate protein calorie malnutrition, chronic obstructive pulmonary disease, chronic kidney disease stage 3, post-traumatic stress disorder, psychophysiologic insomnia, acquired absence of the right leg below the knee, absence of the left leg above the knee, and retention of urine. Review of a significant change MDS assessment for Resident #2 dated 02/06/26 revealed Resident #2 was cognitively intact and was assessed with an indwelling urinary catheter. Review of the revised care plan for Resident #2 dated 02/02/26 revealed no direction on the use of enhanced barrier precautions (EBP) when caring for the suprapubic catheter. Review of Resident #2's orders revealed on 02/27/26 an order was entered for a 16 French suprapubic catheter to be exchanged now and then every four weeks thereafter. Further review of the orders for Resident #2 revealed no order for EBP. Observation on 03/16/26 at approximately 9:00 A.M. revealed Resident #2 activated the call light due to having a wet brief caused by bladder spasms. Shortly after activating call light, Certified Nurse Aide (CNA) #656 entered the room. CNA #656 donned gloves but no gown and provided incontinence care including peri-care and changing the resident's incontinence brief. Interview on 03/16/26 at 9:13 A.M. with CNA #656 verified a gown was not worn while providing incontinence care to Resident #2. CNA #656 stated she was not aware that a gown was needed to be worn to provide incontinence care to a resident with an indwelling urinary catheter. CNA #565 stated she believed Resident #2 was in EBP for wounds and since she was not providing wound care a gown was not needed. Interview on 03/16/26 at 9:15 A.M. with Registered Nurse (RN) #694 revealed she believed Resident #2 was in EBP due to wounds on his buttocks, but she believed those wounds to be healed at that time. RN #694 stated personal protective equipment (PPE) did not need to be worn to provide care to Resident #2 unless wound care was being provided. Review of the EBP sign posted on the door to Resident #2's room revealed staff were to wear gloves and gown when providing high-contact resident care activities such as changing briefs and with device care or use of urinary catheter. Review of the facility policy titled, Enhanced Barrier Precautions, dated 08/2022, revealed when providing high-contact resident care activities to residents with indwelling medical devices (central (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Ayden Healthcare of Waterville		STREET ADDRESS, CITY, STATE, ZIP CODE 8885 Browning Drive Waterville, OH 43566	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	line, urinary catheter, or feeding tube), gloves and gown are to be applied prior to the high contact care activity. 4. Observation on 03/17/26 at 10:50 A.M. revealed Resident #2 was in bed sleeping and the indwelling urinary catheter drainage bag was lying on the floor. There was no barrier between the drainage bag and the floor. Observation on 03/17/26 at 12:58 P.M. revealed Resident #2 was in bed sleeping and the indwelling urinary catheter drainage bag was lying on the floor. There was no barrier between drainage bag and the floor. Interview on 03/17/26 at 1:02 P.M. with CNA #651 verified Resident #2's indwelling urinary catheter drainage bag was on the floor with no barrier between bag and floor. CNA #651 donned gloves and hung the drainage bag on the side of the bed. Review of facility policy titled, Catheter Care, Urinary, revised 09/2014, revealed infection control measures for residents with indwelling urinary catheter's included catheter tubing and drainage bag are to be kept off the floor. 5. Observation on 03/17/26 between 7:05 A.M. and 7:40 A.M. revealed Licensed Practical Nurse (LPN) #692 obtained finger stick blood glucose levels for Resident #53 and Resident #76 and did not wear gloves and did not perform hand hygiene prior to nor after obtaining the finger stick blood glucose levels for Resident #53 and Resident #76. Interview on 03/17/26 at 7:40 A.M. with the Director of Nursing (DON) and LPN #692 confirmed LPN #692 did not wear gloves while obtaining finger stick blood glucose levels and did not perform hand hygiene between residents as noted in the above observation. Review of facility policy dated August 2019 and titled, Handwashing/Hand Hygiene, revealed facility staff would perform hand hygiene before and after direct contact with residents.

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	365617	A. Building B. Wing	03/19/2026

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Ayden Healthcare of Waterville	8885 Browning Drive Waterville, OH 43566

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, resident interview, staff interview, and policy review, the facility failed to ensure a resident was provided a call light that accommodated the resident's needs. This affected one (#7) of one residents reviewed for accommodation of needs. The facility census was 76.Findings include:Review of the medical record revealed Resident #7 was admitted to the facility on [DATE]. Diagnoses included unspecified parkinsonism, acute respiratory failure with hypoxia, paranoid schizophrenia, major depressive disorder, suicidal ideations, dementia, and anxiety disorder. Review of the significant change Minimum Data Set (MDS) assessment for Resident #7 dated 01/06/26 revealed a Brief Interview for Mental Status (BIMS) score of 11 indicating the resident had moderate cognitive impairment. Functional abilities for Resident #7 were assessed as dependence on others for eating, oral hygiene, toileting, showering/bathing, upper/lower body dressing and personal hygiene. Review of the revised care plan dated 12/09/25 revealed Resident #7 had self-care deficits and was at risk for alteration in mood and behavior related to schizophrenia and auditory hallucinations. Additionally, the care plan revealed Resident #7 was at risk for falls related to debilitation and weakness.Observation and interview on 03/17/26 at 8:40 A.M. of Resident #7 revealed she was lying awake in bed with call a light device attached to the top of the mattress near her shoulder. The call light device was a red pull cord string. Resident #7 was asked if she was able to pull the cord and Resident #7 shook her head, No. Resident #7 was asked to lift her right arm and the resident was unable to do so. Resident #7 was asked to open the fingers on her left hand and the resident was only able to open her first finger and thumb. Resident #7 was asked to try and pull the call light cord and the resident was able to bend her left arm back slightly but was unable to pull the string.Interview on 03/17/26 at 8:59 A.M. with Certified Nurse Aide (CNA) #651 revealed she had not seen Resident #7 activate her call light device. CNA #651 stated Resident #7 was unable to move her right arm, had limited movement to her left arm, and her left hand was contracted, but the resident was able to use her pointer finger and thumb. CNA #651 verified Resident #7 was unable to use the current call light device. CNA #651 stated the facility had soft touch call light devices that Resident #7 would be able to activate but they were not able to be used on Resident #7's hall due to the type of outlet needed. CNA #651 stated Resident #7 would not be able to activate her current call light device if help was needed. Review of the policy titled, Quality of Life - Accommodation of Needs, revised 08/2009, revealed a resident's individual needs and preferences, including adaptive devices and modifications to the physical environment, shall be evaluated upon admission and reviewed on an ongoing basis. In order to accommodate individual needs and preferences, adaptations may be made to the physical environment, including the resident's bedroom and bathroom.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interview, and staff interview, the facility failed to ensure residents were bathed per their scheduled preference. This affected one (#46) of three residents reviewed for activities of daily living. The facility census was 76.Findings include:Review of the medical record for Resident #46 revealed he was admitted on [DATE] with diagnoses including chronic respiratory failure, alveolar hypoventilation, morbid obesity, neurogenic bladder, hypertension, dependence on ventilator, chronic obstructive pulmonary disease, asthma, type two diabetes mellitus, depression, and anxiety.Review of the annual Minimum Data Set (MDS) assessment dated [DATE] for Resident #46 revealed he was cognitively intact at the time of the assessment and did not exhibit any behaviors nor refusals of care. The resident was dependent for all activities of daily living and transfers, and was incontinent of bowel and had a urinary catheter in place.Interview on 03/16/26 at 10:45 A.M. with Resident #46 revealed he did not receive bathing care twice a week as scheduled.Review of shower sheets for Resident #46 revealed he did not receive bed baths on 01/04/26, 01/14/26, 01/18/26, for two weeks between 01/21/26 and 02/04/26, 02/08/26, 02/22/26, and not for two weeks between 03/01/26 and 03/15/26.Interview on 03/18/26 at approximately 3:00 P.M. with the Director of Nursing (DON) confirmed Resident #46 was scheduled for bathing on Wednesdays and Sundays and Resident #46 did not refuse bathing. Continued interview confirmed there was no documentation to support Resident #46 received his bed baths on 01/04/26, 01/14/26, 01/18/26, for two weeks between 01/21/26 and 02/04/26, 02/08/26, 02/22/26, or for two weeks between 03/01/26 and 03/15/26.Interview on 03/19/26 at 10:20 A.M. with the DON revealed the facility standard was for residents to be offered bathing scheduled two times per week.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure adequate monitoring for psychotropic medication effectiveness, side effects, and adverse effects was completed. This affected two (#2 and #3) of five residents reviewed for unnecessary medications. The facility census was 76.Findings include:1. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE]. Diagnoses included unspecified head injury, post-traumatic stress disorder (PTSD), and psychophysiologic insomnia. Review of a significant change Minimum Data Set (MDS) assessment for Resident #2 dated 02/06/26 revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #2 was cognitively intact. Resident #2's behaviors were assessed to include physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds happening one to three days in the look back period. Review of the revised care plan dated 02/02/26 for Resident #2 revealed a history of trauma related PTSD related to military history. Interventions included to observe for increasing anxiety, decrease environmental stimulation, provide reassurance and comfort measures if applicable, and to refer to psychiatric services if applicable. Additional review of the care plan for Resident #2 revealed the resident was at risk for alteration in mood and behavior. There was no direction given in regard to monitoring for the side effects of the psychotropic medications ordered for Resident #2. Review of the physician orders for Resident #2 revealed an order entered on 01/28/26 for psychiatric evaluation and treatment as needed. Medication orders for Resident #2 included Ativan oral tablet 0.5 milligrams (mg) by mouth two times a day as needed for anxiety related to generalized anxiety disorder. Continued review of medication orders revealed an order for mirtazapine 7.5 mg by mouth at bedtime for sleep related to insomnia related depression. There were no physician orders initiated to monitor the side effects of psychotropic medications.2. Review of the medical record revealed Resident #3 was admitted to the facility on [DATE]. Diagnoses included aphasia, hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, schizoaffective disorder, and personal history of traumatic brain injury.Review of the quarterly MDS for Resident #3 completed on 12/12/25 revealed a BIMS score of 15 indicating Resident #3 was cognitively intact. Continued review of MDS revealed Resident #3 felt down and depressed two to six days during the look back period and no behaviors were exhibited at the time of the assessment. Review of the revised care plan for Resident #3 dated 02/27/26 revealed a risk for behavior symptoms such as exit-seeking or throwing self on the floor when the resident was upset. Further review of the care plan for Resident #3 revealed a risk for changes in mood related to depression, diagnosis of bipolar disorder, and antidepressant and antipsychotic medications. Continued review of the care plan revealed no direction given in regard to monitoring for the side effects of the psychotropic medications. Review of the physician orders for Resident #3 revealed an order initiated on 12/19/25 for psychiatric services evaluation and treatment as needed. Medication orders initiated for Resident #3 included divalproex sodium oral tablet delayed release 125 mg by mouth twice a day related to schizoaffective disorder, bipolar type as well as mirtazapine tablet 7.5 mg by mouth at bedtime for weight loss related to major depressive disorder. Further review revealed no orders entered to monitor the side effects of psychotropic medications.Interview on 03/18/26 at 2:00 P.M. with the Director of Nursing (DON) revealed the order used by the facility to monitor the side effects of psychotropic medications was a house order and if the order was not seen in Resident #2 and Resident #3's active orders then the button was not clicked. The DON stated she would look elsewhere for documentation that monitoring of the side effects of psychotropics for Resident #2 and Resident #3 was completed. Interview on 03/19/26 at 7:58 A.M. with the DON revealed Residents #2 and Resident #3 did not have an active order to monitor (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for psychotropic medication side effects. The DON verified monitoring for psychotropic medication side effects for Resident #2 and Resident #3 was not completed. The DON further stated the order to monitor for psychotropic medication side effects was entered for Resident #3 that morning.

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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 medical record review, review of electronic mail (email) documents, staff interview, and review of facility policy, the facility failed to ensure a resident was provided a safe and appropriate discharge. This affected one (#84) of three residents reviewed for transfer and discharge. The facility census was 76.Findings include: Review of Resident #84's medical record revealed an admission date of 09/23/25 and a discharge date of 02/13/26. Diagnoses included epilepsy, traumatic brain injury, anxiety disorder, mood disorder, depression, tracheostomy status, and thyroiditis.Review of Resident #84's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of zero indicating Resident #84 was rarely or never understood. A Staff Assessment for Mental Status was completed and Resident #84 was noted to have short and long term memory problems. Resident #84 required moderate assistance with toilet use, bathing, and dressing. Resident #84 displayed physical behavioral symptoms directed toward others, verbal behavioral symptoms directed toward others, and rejection of care one to three days during the review period. Resident #84 displayed other behavioral symptoms and wandering behaviors four to six days of the review period. Review of Resident #84's care plan initiated on 09/23/25, and cancelled on 02/20/26, revealed supports and interventions for being at risk for decline in activities of daily living, at risk for falls, at risk for alteration in comfort, a discharge plan to return home to a safe environment of her choice, cognitive impairment, notation that the resident could become fearful and agitated in group activities, and was at risk for alteration in mood and behaviors. Resident #84's behaviors included crying, tearfulness, yelling help me, repeatedly asking for the same thing, and taking her clothes off and walk down the hallways. Interventions included to acknowledge mood in one-on-one interactions, administer medications as ordered, discuss feelings, encourage loved ones to visit, encourage to wear clothes in the hallway, utilize a weighted blanket to help with mood and comfort, and involve in making own schedule. Review of Resident #84's progress notes from 11/01/25 to her discharge on [DATE] found no instances of Resident #84's behaviors being a risk to herself or other residents. Resident #84's behaviors were directed only toward staff and included hitting, kicking, throwing items, and hitting the medication cart against the wall. Further review revealed no evidence of the facility submitting and referrals to other skilled nursing facilities for alternate placement.Review of a late entry progress note written by the Director of Nursing (DON) dated 02/12/26 at 8:30 P.M. revealed she was notified that Resident #84 was out of control, had hit a nurse, and the police were called. The Administrator and Resident #84's husband were notified. The police were with Resident #84 for approximately one hour to get her to calm down and Physician #200 was emailed who had been caring for Resident #84.Review of an email sent by the DON to Physician #200 on 02/12/26 at 11:37 P.M. revealed Resident #84 needed a psychiatric facility but also needed to be overseen by neurology and the area where the facility was located did not have any facilities which meet that criteria. Further review revealed Resident #84 had gotten physical with staff and the facility was not equipped for her (Resident #84) behaviors and the facility was not sure what to do at this point. The DON asked if there were any service near Physician #200's where the resident could go.Review of a late entry progress note written by the DON on 02/13/26 at 2:29 A.M. revealed she received a call from Physician #200 indicating she and her psychiatric team did not know of a psychiatric facility that had a neurologist on board. Further review revealed Physician #200 recommended Resident #84's husband take the resident to an ER that had a psychiatric center. The DON also asked for information from Resident #84's insurance to determine what hospitals would accept her. Further review of the progress note revealed the DON spoke to Resident #84's husband who was going to take the resident to the ER and he would do research on which hospital to take her to. Resident #84's husband indicated he would not be able to pick the resident up until 9:30 (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	P.M.Review of an email sent by Physician #200 to the DON on 02/13/26 at 8:43 A.M. revealed discussion about adding antipsychotic medication to Resident #84's medication regimen, but first Physician #200 suggested a formal psychiatric evaluation and help with her medications would be the next best step. Further review revealed Physician #200 indicated her facility's inpatient psychiatric units did not have neurology onsite to provider care for Resident #84.Review of a progress note written by Social Services Director (SSD) #603 on 02/13/26 at 4:12 P.M. revealed a information packet was made for Resident #84's husband to take the resident to a hospital for acute psychiatric behaviors.Review of a late entry progress note written by the DON on 02/13/26 at 10:17 A.M. revealed Resident #84's husband was in the ER at a local hospital and he felt the hospital was not going to admit Resident #84. The DON asked the resident's husband to give them her telephone number to speak with them. It was documented Resident #84's husband stated a male in the ER stated this was not even the place for her (Resident #84). Resident #84's husband stated the resident would probably end up at another hospital if she could not come back to the facility.Review of a late entry progress note written by the DON on 02/13/26 at 12:00 A.M. revealed she spoke with the Administrator about Resident #84 being at the hospital, and the hospital not admitting the resident. Further review revealed the husband asked if he could bring the resident back that night. The Administrator called the DON back and stated Resident #84 could not come back to the facility because she was a harm to herself and others. The DON relayed this to Resident #84's husband and stated the ER physicians told him they would not call the DON.Review of an email sent by the DON to Physician #200 on 02/13/26 at 1:13 P.M. revealed she was told by the facility corporate staff that she needed to find a psychiatric facility to send Resident #84 to as soon as possible due to uncontrolled behaviors. Review of an email sent by Physician #200 to the DON on 02/13/26 at 1:23 P.M. revealed she had not heard from her psychiatric team and informed the DON to let her know if the facility found someplace local to transfer Resident #84.Review of a late entry progress note written by the DON on 02/14/26 at 1:45 A.M. revealed she was notified by Resident #84's husband that psychiatric services had finally come to the ER to evaluate the resident. Further review revealed he told the ER staff the facility was not accepting Resident #84 back due to being a harm to herself and others.Review of a late entry progress note written by the DON on 02/14/26 at 2:40 A.M. revealed Resident #84's husband notified the DON that the hospital was not admitting the resident and he had no medications and no place to take the resident. The DON approved for staff to provide Resident #84's husband with the resident's medication for the morning and late afternoon which would give the resident enough medications before being taken to another hospital. Review of a progress note written by Licensed Practical Nurse (LPN) #696 on 02/14/26 at 6:14 A.M. revealed Resident #84 went to the hospital with her husband and the hospital did not admit the resident. The resident was not allowed to return to the facility. The morning and noon dose of medications were given to Resident #84's husband per the DON's request as well as the resident's belongings. Resident #84's husband was upset that the resident could not return to the facility and was taking the resident home. Review of a late entry progress note dated 02/14/26 at 3:36 P.M. revealed the facility spoke with Resident #84's husband who indicated the resident was home, was very confused, but was safe. He stated he spoke with Physician #200 and she was calling in Resident #84's medications to be obtained, and if he was not able to afford them, then he needed to take Resident #84 to the ER.Review of discharge instructions dated 02/14/26 revealed Resident #84 was discharged home from the hospital with her husband as care giver. A home health referral was to be sent the following Monday (02/16/26) for physical, occupational, and speech therapy, as well as nursing needs. No durable medical equipment was needed for the resident. The resident's medications were called in by Resident #84's neurologist, however, the resident's medications were not common and the facility received approval from the Medical Director to send the resident's medications home with her. Medication instructions were given to Resident #84's husband and told the importance of the resident receiving her seizure medications and need to contact the neurologist and take the resident to the ER if any seizures were (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	noted. The resident required 24 hour supervision, especially while in the kitchen, showering, and using stairs. Review of Resident #84's medical record revealed no documentation of the facility providing Resident #84 or her husband of a discharge notice prior to being discharged or rights to appeal the discharge.Interview on 03/18/26 at 8:05 A.M. with the DON verified Resident #84 had no behaviors directed toward other residents or herself. The DON reported all of Resident #84's behaviors were directed toward staff. Resident #84 had no episode to justify transfer to the ER for mental health evaluation and treatment via squad, so Resident #84's husband was spoken to about Resident #84's continued behaviors toward staff. Resident #84's husband agreed to pick Resident #84 up and take her to the hospital ER. The DON verified Resident #84 was not admitted to the hospital and was not permitted to return to the facility. The DON reported she contacted the facility corporate offices and was advised Resident #84 was not permitted to return to the facility because she was a risk to herself and others. The DON verified Resident #84's husband was upset Resident #84 was not able to return to the facility and reported she arranged for Resident #84 to get her medications for the next day. The DON reported Resident #84 received her scheduled medications before she left the facility around 9:30 A.M. and had not missed any doses. The DON stated Resident #84's husband took the resident and the husband told her the first night Resident #84 was confused but was sleeping and eating well. The plan was for Resident #84's brother to stay with the resident and the husband so Resident #84's husband could go back to work. Review of the facility policy titled, Transfer and Discharge, revised August 2024 revealed it was the policy of the facility to permit each resident to remain in the facility and not transfer or discharge the resident from the facility excepts when the resident or responsible party requests, when the resident or the responsible party was no actively paying, or when the health and safety of the individual or other residents were endangered.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, medical record review, resident and staff interview, and policy review, the facility failed to ensure pressure ulcer prevention measures were in place as ordered. This affected one (#11) of one residents reviewed for pressure ulcers. The facility census was 76.Findings include:Review of the medical record for Resident #11 revealed an admission date of 03/28/21 with diagnoses of hemiplegia and hemiparesis, aphasia, and anxiety. Review of the annual Minimum Data Set (MDS) assessment, dated 01/16/26, revealed Resident #11 had impaired cognition and was dependent on staff for transfers and mobility. Further review revealed Resident #11 was at risk for skin breakdown and had no pressure ulcers at the time of the assessment.Review of the care plan initiated 01/05/22, and revised 03/19/26, revealed Resident #11 was at risk for impaired skin integrity related to activities of daily living (ADL) needs, incontinence, and frail/thin skin. Interventions included use of pressure reduction devices as needed. Further review revealed Resident #11 was at risk for decline in ADL function and/or ADL participation as evidenced by the need for total assistance with ADLs, mechanical lift (Hoyer) transfers, Broda chairs (a specialized positioning chair) and toileting related to requiring staff total care for ADLs. Review of the current physician order, dated 12/13/22, revealed Resident #11 had orders per wound care for bilateral protective boots as tolerated to be removed for hygiene and skin care.Observation on 03/17/26 at 7:38 A.M. revealed Resident #11 in her room in an adjustable reclining wheelchair. Further observation revealed two offloading boots on the dresser behind her television. Concurrent interview with Resident #11 revealed she would allow staff to put the offloading boots on her.Observation on 03/17/26 at 9:56 A.M. revealed Resident #11 in an adjustable reclining wheelchair in the interim dining room. Resident #11 had a blanket covering her body, legs, and feet. Resident #11's arms were outside the blanket. Concurrent interview with Resident #11 revealed she could not move her legs independently. Interview on 03/17/26 at 10:30 A.M. with Certified Nurse Aide (CNA) #682, who was assigned to Resident #11, stated the staff was about to provide personal care to Resident #11. CNA #682 stated the shift began at 6:30 A.M. and Resident #11 was transferred from the bed to the wheelchair on the previous shift. CNA #682 further stated he had not provided care to Resident #682 since the beginning of his shift on Resident #11's hall four hours earlier, and was in the process of finding a mechanical lift to assist in transferring Resident #682 from the chair to the bed to provide care. Continued observation and interview outside the door to Resident #11's room with CNA #682 confirmed Resident #11's offloading boots were in the room and not on Resident #11. CNA #682 stated the boots were intended to be used while Resident #11 was in bed. Continued observation on 03/17/26 revealed CNA #682 was assisted by CNA #635 as they wheeled Resident #11 from the interim dining room toward Resident #11's room. Concurrent observation revealed CNA #635 moved the blanket covering Resident #11's feet. Resident #11's legs were crossed at the ankle and one heel was resting on the footpad of the adjustable wheelchair. Concurrent interview with CNA #635 confirmed Resident #11's heel was resting on the footpad. Follow-up interview on 03/17/26 at approximately 2:00 P.M. with CNA #635 revealed she placed Resident #11's offloading boots on both feet after the earlier observation of her heel resting on the wheelchair footpad. Review of the weekly body audit dated 03/18/26 revealed Resident #11 had no skin breakdown.Review of the policy titled, Skin Management Program, dated 04/2023, revealed interventions will be implemented that are person-centered and measurable. Interventions may include but are not limited turning and repositioning and offloading heels.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on medical record review, staff interview, and policy review, the facility failed to ensure non-pharmacological interventions were attempted prior to receiving an as-needed pain medication. This affected one (#63) of one residents reviewed for pain. The facility census was 76.Findings include:Review of the medical record for Resident #63 revealed an admission date of 04/02/25 with diagnoses of dementia, rheumatoid arthritis, disc degeneration, and neuropathy. Review of the quarterly Minimum Data Set (MDS) assessment, dated 12/24/25, revealed Resident #63 had intact cognition, received as-needed pain medications, and did not receive non-medication interventions for pain.Review of the care plan, initiated 04/03/25, revealed Resident #63 was at risk for alteration in comfort due to complaints of pain, generalized pain, and gastroesophageal reflux disease. Interventions included but were not limited to staff attempting non-pharmacological interventions if the resident allowed.Review of the physician order dated 11/21/25 revealed Resident #63 received oxycodone hydrochloride (HCl) oral tablet, five (5) milligrams (mg), one tablet by mouth every six hours as needed for pain. Review of Resident #63's February 2026 medication administration record (MAR) revealed Resident #63 received 59 doses of oxycodone HCl.Review of the March 2026 MAR revealed Resident #63 received 28 doses of oxycodone HCl between 03/01/26 and 03/17/26 at 4:00 P.M.Further review of Resident #63's medical record revealed no evidence of non-pharmacological interventions prior to administration of the as-needed doses of oxycodone HCl in February and March 2026.Interview on 03/19/26 at 8:24 A.M. with Licensed Practical Nurse (LPN) #630 confirmed non-pharmacological interventions should be attempted prior to administering as-needed pain medication. Further interview, and concurrent review of Resident #63's medical record, confirmed no evidence Resident #63 received non-pharmacological pain interventions prior to receiving as-needed doses of oxycodone HCl.Review of the policy titled, Pain Assessment and Management, revised 03/2020, revealed guidance for implementing pain management strategies included non-pharmacological interventions may be appropriate or alone in conjunction with medications.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of facility guidelines, the facility failed to ensure resident-specific interventions were implemented to address a resident's history of trauma. This affected three (#63, #13 and #2) of three residents reviewed for trauma informed care and treatment. The facility census was 76. Findings include:1. Review of the medical record for Resident #63 revealed an admission date of 04/02/25 with diagnoses of dementia, bipolar disorder, and depression. Review of the Minimum Data Set (MDS) assessment, dated 12/24/25, revealed Resident #63 had intact cognition. Review of Resident #63's comprehensive care plan, initiated 04/02/25 and revised 04/15/25, revealed Resident #63 had trauma related to sexual abuse. Interventions included providing reassurance and comfort measures if applicable; provide visits to the resident to communicate the activity schedule and encourage the resident to participate in social interactions; and referral to psychiatric services and/or counseling services as warranted. Interview on 03/19/26 at 8:10 A.M. with the Director of Nursing (DON), Licensed Practical Nurse (LPN) #630, and Social Service Director #603 confirmed Resident #63's care plan did not include any trauma-specific triggers or interventions to address and/or avoid Resident #63's trauma-specific triggers. 2. Review of the medical record revealed Resident #13 was admitted to the facility on [DATE]. Diagnoses included morbid obesity, neuromuscular dysfunction of the bladder, and fracture of an unspecified part of the neck of the right femur. Review of the MDS assessment dated [DATE] for Resident #13 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #13 was cognitively intact. Resident #13 was dependent on staff for all activities of daily living (ADLs). Review of the care plan dated 03/11/26 revealed Resident #13 had a history of trauma related to being in a situation/environment and being a victim of a violent crime with goals that included Resident #13 will express triggered stresses, traumatic events, and how to cope with them. Interventions included displaying warmth, answering questions, offering unconditional acceptance, being available, and respecting the residents use of personal space. There were no identified trauma triggers noted in the care plan. Interview on 03/19/26 at 8:00 A.M. with the DON verified the care plan for Resident #13 contained no specific triggers for the residents past trauma. The DON also verified the interventions for the resident's trauma-informed care were not specific to the resident. 3. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE]. Diagnoses included unspecified head injury, post-traumatic stress disorder (PTSD), and psychophysiologic insomnia. Review of a significant change MDS assessment for Resident #2, dated 02/06/26, revealed Resident #2 was cognitively intact. The resident was assessed with behaviors including physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or smearing food or bodily wastes, or verbal/vocal symptoms like screaming or disruptive sounds occurring one to three days on the look back period. Review of the revised care plan dated 02/02/26 for Resident #2 revealed a history of trauma-related PTSD from military history with interventions to establish and maintain a trusting relationship by listening to the resident. Further interventions included to observe for increasing anxiety, decrease environmental stimulation, provide reassurance and comfort measures if applicable and to refer to psychiatric services if applicable. Additional review of the care plan for Resident #2 revealed the resident was at risk for alteration in mood and behavior. The care plan for Resident #2 revealed no resident-specific PTSD triggers. Interview on 03/19/26 at 8:00 A.M. with the DON verified the care plan for Resident #2 contained no specific PTSD triggers. The DON stated the interventions for trauma-informed care for Resident #2 were not resident-specific due to lack of triggers. Review of the facility guidelines that were followed and provided by the facility titled, Trauma-Informed Care, Implementing a Trauma-Informed Approach Talking Points, revised in 2021, revealed the facility was to ensure that residents who are trauma survivors receive culturally competent, trauma-informed care accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization.

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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. Based on medical record review and staff interview, the facility failed to ensure medications were administered per physician order. This affected one (#63) of five residents reviewed for medications. The facility census was 76.Findings include:Review of the medical record for Resident #63 revealed an admission date of 04/02/25 with diagnoses of dementia, hypertension, and anxiety. Review of the Minimum Data Set (MDS) assessment, dated 12/24/25, revealed Resident #63 had intact cognition.Review of the physician order dated 08/29/25 revealed Resident #63 received midodrine hydrochloride (HCl) tablet 2.5 milligrams (mg) to give one table by mouth every eight hours for hypotension with instructions to give the medication for systolic blood pressure (SBP; the reading of pressure against the artery walls when the heart beats and is represented as the top number of a blood pressure reading) less than 100 millimeters of Mercury (mmHg). Review of Resident #63's February 2026 medication administration record (MAR) revealed Resident #63 received midodrine HCl on 02/09/26 at 10:00 P.M. for a blood pressure (BP) of 124/50 mmHg, on 02/16/26 at 2:00 P.M. for a BP of 117/58 mmHg, on 02/19/26 at 2:00 P.M. for a BP of 125/72 mmHg, on 02/20/26 at 10:00 P.M. for a BP of 163/59 mmHg, on 02/21/26 at 10:00 P.M. for a BP of 104/76 mmHg, on 02/22/26 at 10:00 P.M. for a BP of 108/62 mmHg, on 02/23/26 at 6:00 A.M. for a BP of 106/69 mmHg, on 02/25/26 at 2:00 P.M. for a BP of 106/54 mmHg, on 02/27/26 at 6:00 A.M. for a BP of 126/57 mmHg, and on 02/28/26 at 2:00 P.M. for a BP of 108/74 mmHg.Review of Resident #63's MArch 2026 MAR revealed Resident #63 received midodrine HCl on 03/06/26 at 10:00 P.M. for a BP of 143/51 mmHg.Interview on 03/19/26 at 9:13 A.M. with Unit Manager #683 confirmed Resident #63 received midodrine HCl outside the ordered parameters on 02/09/26, 02/16/26, 02/19/26, 02/20/26, 02/21/26, 02/22/26, 02/23/26, 02/25/26, 02/27/26, 02/28/26, and 03/06/26.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interview, medical record review, and policy review, the facility failed to ensure medications were stored in a secure manner. This affected one (#9) of one residents reviewed for hemodialysis and related care. The facility census was 76.Findings include:Review of the medical record for Resident #9 revealed an admission date of 05/13/21 with diagnoses of dementia, heart disease, and end stage renal disease. Review of the Minimum Data Set (MDS) assessment, dated 12/23/25, revealed Resident #9 had intact cognition and received dialysis.Review of the current physician order, initiated 01/09/26, revealed Resident #9 received midodrine hydrochloride (HCl) oral tablet 10 milligrams (mg) with instructions to give 10 mg orally in the afternoon every Monday, Wednesday, and Friday, and send with the resident to dialysis.Review of the current physician order, initiated 01/20/26, revealed Resident #9 went to an offsite hemodialysis (HD) clinic three times weekly and as needed for HD.Interview on 03/17/26 at 10:23 A.M. with Registered Nurse (RN) #706 revealed Resident #9's HD communication binder was located in the bag in Resident #9's room. Observation and interview on 03/17/26 at 10:45 A.M. with Certified Nurse Aide (CNA) #644 and Resident #9, in Resident #9's room, revealed a tote bag on Resident #9's recliner, zipped, and closed. Further observation, with Resident #9's permission, revealed Resident #9's HD notebook inside the tote bag. Continued observation revealed medication was inside a pouch inside the notebook. CNA #644 confirmed medications were inside the notebook. Continued observation revealed CNA #644 carried the notebook to Licensed Practical Nurse (LPN) #692, who was at the medication cart on the secured unit. Interview on 03/17/26 at 10:48 A.M. with LPN #692, and concurrent observation of Resident #9's HD notebook, revealed a medication card for Resident #9 for midodrine HCl 10 mg containing seven tablets. LPN #692 placed the notebook in a locked drawer of the medication cart. Review of the policy titled, Storage of Medications, revised April 2019, revealed drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light, and humidity controls.

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident representative interview, and staff interview, the facility failed to ensure diagnostic testing results were obtained and communicated in a timely manner. This affected one (#44) of one residents reviewed for diagnostic testing. The facility census was 76.Findings include:Review of the medical record for Resident #44 revealed he was admitted on [DATE] with diagnoses including respiratory failure, depression, anxiety, pneumonia, neurogenic bladder, acute infarction of the spinal cord, hypertension, and gastrointestinal hemorrhage. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] for Resident #44 revealed he was cognitively impaired. Resident #44 experienced functional range of motion limitations on both sides to his upper and lower extremities and was dependent for all care and transfers.Interview on 03/16/26 at 2:23 P.M. with Resident #44's representative revealed diagnostic testing results completed in January 2026 had not been communicated to them.Review of the medical record for Resident #44 revealed a progress note dated 01/20/26 indicating a bone biopsy had been rescheduled for 02/03/26. A progress noted dated 02/03/26 revealed Resident #44 was out of the facility.Review of the medical record for Resident #44 revealed the absence of results from the bone biopsy scheduled on 02/03/26.Interview on 03/18/26 at 10:48 A.M. with the Director of Nursing (DON) confirmed the bone biopsy results had not been obtained by the facility nor communicated to the physician and resident representative.Interview on 03/19/26 at 10:00 A.M. with the Administrator revealed the facility did not have a policy for obtaining diagnostic testing results nor physician and family representative notification of said results.Interview on 03/19/26 at 10:20 A.M. with the DON revealed diagnostic testing results would typically be communicated to the physician within 24 hours.

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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 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. Based on medical record review and staff interview, the facility failed to ensure a resident's medical record was complete to include communication with a dialysis provider. This affected one (#9) of one residents reviewed for hemodialysis. The facility census was 76.Findings include:Review of the medical record for Resident #9 revealed an admission date of 05/13/21 with diagnoses of dementia, heart disease, and end stage renal disease. Review of the Minimum Data Set (MDS) assessment, dated 12/23/25, revealed Resident #9 had intact cognition and received dialysis.Review of a document on the hemodialysis (HD) clinic's letterhead titled, Patient Curfew Letter, dated 10/01/25, revealed Resident #9 was receiving emergency HD treatments at the clinic in the area and the scheduling of the treatments required him/her to be traveling through the area during hours before and after curfew. Review of Resident #9's nursing progress notes dated 10/01/25 through 02/25/26 revealed communication between the facility and Resident #9's HD clinic was documented on 10/31/25, 11/13/25, 12/08/25, and 02/25/26.Review of the current physician order, dated 01/20/26, revealed Resident #9 went to an offsite HD clinic three times weekly and as needed for HD.Review of the care plan, initiated 04/09/24 and revised 03/19/26, revealed Resident #9 received dialysis Mondays, Wednesdays, and Fridays. Interventions included to check for new orders upon return from dialysis (initiated 04/09/24) and maintain communication with dialysis staff and physician (initiated 03/19/26). Interview on 03/17/26 at 10:23 A.M. with Registered Nurse (RN) #706 revealed staff obtained Resident #9's vital signs and checked the fistula (dialysis access site) and the dressing before and after each HD treatment. Interview on 03/18/26 at 10:45 A.M. with Licensed Practical Nurse (LPN) #659 stated Resident #9's HD clinic stayed in very good communication with the facility and called if there were any emergency needs. LPN #659 stated the HD clinic did not often send any paperwork back with Resident #9. Interview on 03/19/26 at 12:02 P.M. with the Director of Nursing (DON) revealed there was no expectation the facility would send information with Resident #9 to the HD clinic on dialysis days. Continued interview on 03/19/26 with the DON and Unit Manager #683 revealed the facility received electronic mail (email) and telephone calls from the HD clinic and stated there was ongoing communication with the HD clinic. Further interview confirmed the ongoing exchange of information with the HD clinic was not routinely documented in the resident's medical record.