

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365684	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/22/2026
NAME OF PROVIDER OR SUPPLIER Northwood Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 Villa Road Springfield, OH 45503	
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 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 interviews, and policy review, the facility failed to store, prepare, and serve food in a safe and sanitary manner. This had the potential to affect all residents residing in the facility. The facility census was 69. Observation 06/14/26 at 8:58 A.M. of the walk in cooler revealed lemonade that was undated, chicken salad with a discard date of 06/11/26, and coleslaw with a discard date of 05/26/26. Interview on 06/14/26 at 8:59 A.M. with Dietary Supervisor (DS)#273 verified the lemonade did not have a date and that the chicken salad and coleslaw should have been discarded. Observation on 06/14/26 at 9:01 A.M. revealed a can of shasta cola stored under raw meats of the walk in cooler. Interview with DS #273 verified the soda should not have been stored below raw meat. Observation on 06/14/26 at 9:01 A.M. in the walk in freezer revealed homemade bread cruotons with a use by date of 06/04/26, concurrent interview with DS #273 verified that the cruotons should have been discarded. Observation on 06/14/26 at 9:19 A.M. revealed two knives with missing chips on blade being stored in the knife rack. Interview with DS #273 verified that the knives had missing metal chips on the blade and he was planning on replacing them. Observation on 06/14/26 at 9:19 A.M. revealed two cans of pears with dents being stored on the can stoage rack in the dry stock area. Concurrent interview with DS #273 verified that the cans were dented and should have been discarded. Observation on 06/14/26 at 9:21 A.M. revealed a bulk bag of opened panko bread crumbs which was undated. Concurrent interview with DS #273 verified that the bag should have been dated when it was opened. Review of the facility policy titled, Food Receiving and Storage dated October 2017 revealed all food stored in the refridgerator or freezer will be covered, labeled, and dated. Uncooked and raw animal products will stored seperately and below ready to eat foods. Review of the facility policy titled, Sanitization dated October 2008 revealed revealed all utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosion, open seams, cracks and chipped areas.		

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 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, staff interview, and policy review, the facility failed to maintain an effective pest control program. This had the potential to affect all residents residing in the facility. The facility census was 69. Observation on 06/14/26 at 8:56 A.M. revealed several gnats flying around near the dish machine. Interview on 06/14/26 at 9:25 A.M. with Dietary Supervisor #273 verified they have been having a problem with gnats in the dish washing area and he was planning to have the pest control company come out to treat the area. Review of the pest control reports since 02/19/26 revealed fly activity was observed in the kitchen on 02/19/26, 04/10/26, and 06/02/26. Review of the facility policy titled, Sanitization dated October 2008 revealed all kitchen areas will be kept clean and protected from rodents, roaches, flies, and other insects.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	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 record review, interview and facility policy review the facility failed to ensure a safe smoking environment when residents had their own cigarettes and lighter, this affected three residents (#32, #43, and #68), the facility also failed to maintain a smoking blanket in good condition, this had the potential affect all twenty residents (#01, #02, #05, #06, #07, #11, #12, #16, #19, #24, #29, #32, #39, #40, #42, #43, #47, #50, #67, and #68) the facility identified as smokers , and the facility failed to accurately assess one resident (#45) for wandering/elopement. The facility census was 69. Findings include: 1) Review of the medical record of Resident #32 revealed an admission date of 02/01/26 with diagnoses of ischemic cardiomyopathy, chronic kidney disease stage III, major depressive disorder recurrent, myocardial infarction, and essential hypertension. Review of the care plan dated 02/01/26 revealed Resident #32 required supervision with smoking with interventions of supervise resident per facility policy and store smoking materials per facility policy. 2) Review of the medical record of Resident #43 revealed an admission date of 01/07/26 with diagnoses of essential hypertension, intervertebral disc degeneration, lumbosacral region without mention of lumbar back pain or lower extremity pain, chronic obstructive pulmonary disease, Type II Diabetes Mellitus without complications, and heart failure. Review of the care plan dated 01/07/26 revealed Resident #43 required supervision with smoking with interventions of supervise resident per facility policy and store smoking materials per facility policy. 3) Review of the medical record of Resident #68 revealed an admission date of 12/27/22 with diagnoses of moderate persistent asthma, chronic obstructive pulmonary disease, paranoid personality disorder, other abnormalities of gait and mobility, and Type II Diabetes Mellitus with diabetic neuropathy. Review of the care plan dated 12/27/22 revealed Resident #68 required supervision with smoking with interventions of supervise resident per facility policy and store smoking materials per facility policy. Observation on 06/15/26 at 3:35 P.M. with Nurse Scheduler #280 of resident's smoking revealed nine residents smoking in the designated smoking area in the courtyard. Nurse Scheduler #280 proceeded to hand each resident one cigarette and light the cigarette for the residents with a lighter. Observation on 06/15/26 at 3:47 P.M. while multiple resident's continue to smoke, the fire blanket was located in the fire blanket box. Upon further review the fire blanket box was rusted out at the bottom of the box and fell out of the bottom of the box unto the ground. The fire blanket was noted to (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	have an approximately 4 inch rusted area across the whole blanket. Interview on 06/15/26 at 3:49 P.M. with Nurse Scheduler #280 advised the box for the smoke blanket has been rusted out like that for quite a while. Interview on 06/15/26 at 3:55 P.M. with Director of Housekeeping #316 confirmed the smoke blanket box was rusted out at the bottom, the blanket falls out and the blanket had rust across the blanket. Interview confirmed the fire blanket and fire blanket box need replaced. Observation on 06/15/26 at 3:59 P.M. with Nurse Scheduler #280 confirmed Resident #32, #68, and #43 pulled extra cigarettes out of their shirts and Resident #32 pulled a light out of her shirt. Nurse Scheduler #280 confirmed residents go and buy cigarettes themselves or families do and they hide them, this happens all the time. Nurse Scheduler #280 also confirmed all the resident's smoking at the time were supervised smokers and were not allowed to have their own cigarettes or lighter. Review of the Smoking policy, dated July 2017 revealed the facility will establish and maintain a safe resident smoking practices. Smoking materials must be handed in to the charge nurse who will keep the materials secured. 4) Medical record review for Resident #45 revealed he was admitted to the facility 11/12/25. His diagnoses included lymphedema, chronic ulcer of right calf, essential primary hypertension, chronic kidney disease, obesity, major depressive disorder, rhabdomyolysis, Parkinson's disease, dysphagia, angina pectoris, and acute kidney disease. Review of the Minimum Data Set (MDS) assessment for Resident #45, dated 05/19/26, revealed he was cognitively intact. Resident #45 was dependent on staff for medication administration, oral hygiene, toilet use, bathing, upper body dressing, lower body dressing, and putting on shoes. Review of the progress notes for Resident #45 on 04/09/26 at 12:01 P.M. revealed Resident #45 was found at the front entrance of the facility waiting on Uber transport. The progress note revealed Resident #45 had slight confusion and was argumentative about his right to leave the facility. The facility applied a wander guard to Resident #45's right ankle. The facility documented the provider was notified with no new order. A progress note written on 01/12/26 revealed a late entry note for 1:05 P.M. on 01/12/26 revealed Resident #45 left with family on leave of absence (LOA). A note on 01/12/26 at 7:00 P.M. revealed Resident #45 returned to the facility (no other information provided). Review of the report titled, Elopement Risk Assessment, dated 05/13/26, for Resident #45 revealed the facility marked the report as Resident #45 is physically unable to leave the facility. Review of the care plans for Resident #45 revealed the facility failed to have a care plan related to the placement of Residents #45's wander guard. Review of the order summary for Resident #45 revealed an order, dated 05/18/26, monitor placement and function of wander guard to right ankle every shift. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the Treatment Administration Record (TAR), for June 2026, revealed nothing related to the placement or monitoring of the wander guard. Interview with Resident #45 on 06/15/26 at 9:16 A.M. revealed Resident #45 took Uber to the Apple Store in another city and stayed until the store closed. Resident #45 revealed the store called the facility to pick him up at the store because it was about to close. The facility had the Director of Nursing (DON) pick Resident #45 up from the store. Resident #45 pointed at his ankle and revealed he was frustrated because the wander guard made him feel trapped at the facility. Interview with the Director of Nursing (DON) on 06/15/2026 at 2:49 P.M. confirmed Resident #45 required a wander guard. The DON confirmed no care plan was in place for the wander guard for Resident #45. The DON confirmed the facility failed to list the wander guard order on the Treatment Administration Record for June 2026. The DON confirmed the wander guard was placed on Resident #45 after he attempted to call an Uber driver and go the bank in April 2025. The DON stated the facility felt the need to place the wander guard on Resident #45 after the incident in April 2025 because it was actually the second time Resident #45 had attempted to leave the facility with an Uber driver. The DON revealed the first incident occurred in January 2026 after Resident #45 called an Uber driver and went to another town to have his phone repaired at the Apple store. The DON revealed Registered Nurse (RN) #451 transported Resident #45 back to the facility when the store called the facility at closing time to report Resident #45 was at the store and did not have a way back to the facility. Interview with Resident #45's resident representative (RR) #501 on 06/15/26 at 5:06 P.M. confirmed the no one in the family was aware that Resident #45 called an Uber driver on 01/12/26 and went across town to the Apple store. RR #501 revealed she is frustrated with the facility and the lack of communication and updates related to Resident #45's care. RR #501 revealed RN #451 transported Resident #45 back to the facility on [DATE] and the facility told her Resident #45 was so heavily soiled when he returned to the facility that Resident #45 made a mess in RN #45's car. Interview with the previous DON, RN #450 on 06/16/2026 at 9:07 A.M. revealed Resident #45 went on leave of absence (LOA) on 01/12/26 and took an Uber to another town to get his Apple phone repaired. Resident #45 stayed until the store closed and was unable to get a ride back to the facility. The Apple store called the facility and RN #450 transported Resident #45 back to the facility in her own vehicle. RN #450 confirmed Resident #45 was very heavily soiled. Interview with Medical Doctor (MD) #500 on 06/16/26 at 10:13 A.M. confirmed he is the physician for Resident #45. MD #500 confirmed he was not aware of Resident #45 having a wander guard until a few weeks ago when Resident #45 expressed feelings of feeling like a prisoner because of wearing a wander guard. MD #500 denied any knowledge of the physician order written by MD #500 for the wander guard. MD #500 revealed the facility has him sign 12,000 orders a month and is not aware of all the orders he signs. Review of the facility policy titled, Wandering and Elopements, dated March 2019, confirmed the facility The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If the facility identified a Resident is at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on review of the menu, review of the menu spread sheet, observation, and staff interview, the facility failed to follow menus for residents with a pureed diet. This affected five (#28, #33, #37, #44, and #45) of five residents the facility identified with an order for a puree diet. The facility census was 69. Review of the menu for 06/15/26 revealed lunch was garlic herb beef pot roast, mashed potatoes, normandy vegetable blend, wheat bread, brown gravy, and oreo cookie blodies. Review of the menu spread sheet for 06/15/26 revealed residents with a puree diet should recieve pureed pot roast, mashed potatoes, pureed veggie blend, pureed bread, brown gravy, and pureed blondie. Observation on 06/15/26 12:00 P.M. revealed residents with a puree diet were not being served bread and were served apple sauce as a substitute for the cookie blondie. Interview with [NAME] #258 verified residents with a pureed diet were not being served bread or a cookie blondie. Interview on 06/15/26 at 12:05 P.M. with Dietary Supervisor #273 verified the facility had the supplies to make pureed bread and pureed cookieblondies, but the facility had not made thses food items according to the pureed menu.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review, the facility failed to residents with a dignified dining experience. This affected one (#26) of the 13 residents reviewed for dining. The facility also failed to ensure resident rights were honored. This affected one (#45) of the one reviewed for resident rights. This facility census was 69. Findings include: 1) Review of the medical record revealed Resident #26 was admitted on [DATE] with diagnoses including type 2 diabetes mellitus and depression. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #26 was cognitively intact. Resident #26 required set up and clean up assistance with eating. Observation on 06/14/26 at 12:34 P.M., revealed Dietary Aide (DA) #236 delivered food to the dining room from the kitchen and began serving the residents their meal. Observation on 06/14/26 at 12:44 P.M., revealed DA #236 delivered a second food cart from the kitchen and began serving the rest of the resident their meals. Observation on 06/14/26 at 12:47 P.M., revealed Resident #26 was at a table by herself without any food. All the other residents in the dining room were served their meal. During an interview on 06/14/26 at 12:48 P.M., Resident #26 stated it bothered her that she was the only resident that was not served a meal in the dining room. During an interview on 06/14/2026 at 12:49 P.M., Activities Director (AD) #260 stated she frequently helps in the dining room. AD #260 stated all food in the dining room was made to order. AD #260 stated the dietary aide would take all the residents orders and then notify the kitchen of the orders. AD #260 verified that Resident #26 was the only resident without a meal in the dining room. During an interview on 06/14/2026 at 12:51 P.M., DA #236 stated she took Resident #26's order at the same time as the other residents. DA#236 stated Resident #26 had ordered what was on the menu for the day and did not request a special order. DA #236 stated she had Resident #26's order ready, she just didn't have room on the cart to bring it out with the others. Observations of the kitchen on 06/14/26 at 12:54 P.M. with DA #236, revealed there was no meal made for Resident #26. DA #236 was observed plating food for Resident #26. During an interview with DA #236 at the same time, verified that the plate she was making was for Resident #26. Observation on 06/14/2026 at 12:57 P.M., revealed Resident #26 received her meal. 2) Medical record review for Resident #45 revealed he was admitted to the facility 11/12/25. Diagnoses included lymphedema, chronic ulcer of right calf, essential primary hypertension, chronic kidney disease, obesity, major depressive disorder, rhabdomyolysis, Parkinson's disease, dysphagia, angina pectoris, and acute kidney disease. Review of the progress note for Resident #45 dated 01/12/26 at 1:05 P.M., revealed the resident left with family on leave of absence (LOA). Review of the progress note for Resident #45 on 01/12/26 at 7:00 P.M., revealed Resident #45 returned to the facility. There was no other information documented. Review of the MDS assessment for Resident #45 dated 05/19/26, revealed the resident was cognitively intact. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the progress note for Resident #45 dated 04/09/26 at 12:01 P.M., revealed the resident was found at the front entrance of the facility waiting for an Uber ride. Resident #45 had slight confusion and was argumentative with staff about his right to leave the facility. The facility applied a Wanderguard to Resident #45's ankle and the provider was notified with no new orders. Review of an Elopement Risk Assessment for Resident #45 dated 05/13/26, revealed the Resident #45 was physically unable to leave the facility. Review of the physician's order for Resident #45 dated 05/18/26, revealed the resident was ordered to have a Wanderguard placed and the placement and function monitored twice daily. Review of the June 2026 Treatment Administration Record (TAR) for Resident #45 revealed no documentation related to the placement or monitoring of the Wanderguard. Review of the active care plans for Resident #45, revealed no care plan related to the placement of the residents Wanderguard. During an interview on 06/15/26 at 9:16 A.M., Resident #45 stated in January he took an Uber to the Apple Store in another city and stayed until the store closed. Resident #45 stated the store called the facility to pick him up because it was about to close. Resident #45 stated someone from the facility picked him from the store. Resident #45 pointed to his ankle and stated he was frustrated because the Wanderguard made him feel trapped in the facility. During an interview on 06/15/2026 at 2:49 P.M., the DON stated Resident #45 required a Wanderguard after an incident in January 2026 when the resident called an Uber and went to another town to have his phone repaired at the Apple store. The Apple store called the facility when they were closing, and a staff member had to go there and pick him up. The DON stated in April 2026, the resident called an uber to go to the bank. The DON verified there was no active care plan in place for the Wanderguard and the Wanderguard was not listed on the TAR for monitoring of the device. During an interview with on 06/15/26 at 5:06 P.M., Resident#45's Representative (RR) #501 stated no one in the family was aware Resident #45 called an Uber driver on 01/12/26 and went across town to the Apple store. RR #501 stated she was frustrated with the facility and the lack of communication and updates related to Resident #45's care. RR #501 stated a staff member transported Resident #45 back to the facility on [DATE] and the resident was so heavily soiled when he returned to the facility that Resident #45 made a mess in the staff members car. During an interview on 06/16/26 at 9:07 A.M., Registered Nurse (RN) #450 stated Resident #45 went on a LOA on 01/12/26 and took an Uber to another town to get his Apple phone repaired. Resident #45 stayed until the store closed and was unable to get a ride back to the facility. The Apple store called the facility and RN #450 transported the resident back to the facility in her own vehicle. RN #450 stated Resident #45 was heavily soiled. During an interview on 06/16/26 at 10:13 A.M., Medical Doctor (MD) #500 stated he was the physician for Resident #45. MD #500 stated he was not aware of Resident #45 having a Wanderguard in place until a few weeks ago when Resident #45 expressed feelings of feeling like a prisoner because of having to wear a Wanderguard. MD #500 denied any knowledge of the physician order written by MD (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	#500 for the wander guard. MD #500 stated he signs over 12,000 orders a month and is not aware of all the orders he signs. Review of the facility policy titled, Resident Rights dated December 2026, revealed employees shall treat all residents with kindness, respect, and dignity. Review of the facility policy titled, Wandering and Elopements, dated March 2019, confirmed the facility The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If the facility identified a Resident is at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure a resident receiving psychotropic medications signed a consent for the use of those medications, and after the risks and benefits associated to their use were explained to the resident/resident's responsible party. This affected one (Resident #08) of five residents reviewed for unnecessary medications. The facility census was 69. Findings include: Review of Resident #08's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included non-Alzheimer's dementia, diabetes mellitus (DM), anxiety and bipolar disorders. Review of the Minimum Data Set (MDS) 3.0 assessment for Resident #08 dated 04/30/26, revealed a Brief Interview for Mental Status (BIMS) score of 07, indicating severe cognitive impairment. Resident #08 had verbal behaviors directed at others. Review of physician orders for Resident #08 dated 04/06/26, revealed the resident was ordered Olanzapine (antipsychotic) five milligrams (mg) at bedtime. Review of the medical record for Resident #08, revealed no therapeutic consent by the resident / resident's representative and no progress note regarding notification to responsible party. During an interview on 06/16/26 at 9:00 A.M., the Director of Nursing (DON) #266 verified the facility did not have any documented evidence to support Resident #08 or a representative signed a consent or notification of the antipsychotic medications.		

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. Based on medical record review and staff interview, the facility failed to notify the state mental health authority via a Pre-admission Screening and Resident Review (PASARR) process when a resident had a significant change in condition which resulted in a new diagnosed mental health condition. This affected one resident (#03) of two residents reviewed for PASARR. The facility census was 69. Findings include: Review of the medical record for Resident #03 revealed an admission date of 02/24/25 with diagnoses of pleural effusion, epilepsy and anxiety disorder. New diagnosis on 07/16/25 to include schizoaffective depressed type. Review of the Minimum Data Set (MDS) 3.0 assessment for Resident #03 dated 04/23/26, revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. Review of Resident #03's medical record on 06/16/26 at 12:30 P.M., revealed on 07/16/25 at 9:26 A.M., Resident #03 received a newly identified diagnosis of schizoaffective depressed type and no PASARR was completed to reflect the updated mental health diagnosis. During an interview on 06/16/26 at 12:34 P.M., Regional Director of Operations (RDO) #600, verified Resident #03 was diagnosed with schizoaffective depressed type on 07/16/25 and a new PASARR was not completed for the change in condition. RDO #600 stated the facility did not have a policy on the PASARR process.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 medical record review, staff interview, resident interview, and facility policy review the facility failed to complete comprehensive care plans for residents. This affected four Residents (#45, #02, #33, and #09) of the four residents reviewed for care plans. The facility census was 69. Findings include: 1) Medical record review for Resident #45 revealed he was admitted to the facility 11/12/25. His diagnoses included lymphedema, chronic ulcer of right calf, essential primary hypertension, chronic kidney disease, obesity, major depressive disorder, rhabdomyolysis, Parkinson's disease, dysphagia, angina pectoris, and acute kidney disease. Review of the progress note for Resident #45 dated 01/12/26 at 1:05 P.M., revealed the resident left with family on leave of absence (LOA). Review of the progress note for Resident #45 on 01/12/26 at 7:00 P.M., revealed Resident #45 returned to the facility. There was no other information documented. Review of the Minimum Data Set (MDS) assessment for Resident #45 dated 05/19/26, revealed the resident was cognitively intact. Review of the progress note for Resident #45 dated 04/09/26 at 12:01 P.M., revealed the resident was found at the front entrance of the facility waiting for an Uber ride. Resident #45 had slight confusion and was argumentative with staff about his right to leave the facility. The facility applied a Wanderguard to Resident #45's right ankle and the provider was notified with no new orders. Review of an Elopement Risk Assessment for Resident #45 dated 05/13/26, revealed the Resident #45 was unable to leave the facility. Review of the physicians order for Resident #45 dated 05/18/26, revealed the resident was ordered to have a Wanderguard placed and the placement and function monitored twice daily. During an interview on 06/15/26 at 9:16 A.M., Resident #45 pointed to his ankle and stated he was frustrated because the Wanderguard made him feel trapped in the facility. Review of the active care plans for Resident #45 on 06/15/26 at 2:45 P.M., revealed there was no comprehensive care plan related to the placement of the residents wander guard. During an interview on 06/15/2026 at 2:49 P.M., the Director of Nursing (DON) stated Resident #45 required a wander guard after an incident in January 2026 when he called an Uber and went to another town to have his phone repaired at the Apple store. The Apple store called the facility when they were closing, and a staff member had to go there and pick him up. The DON stated in April 2026, the resident called an uber to go to the bank. The DON verified there was no active care plan in place for the Wanderguard and the Wanderguard was not listed on the TAR for monitoring of the device. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	2) Medical record review for Resident #02 revealed she was admitted to the facility on [DATE]. Her diagnoses included essential primary hypertension, bradycardia, hyperlipidemia, congestive heart failure, diabetes mellitus (DM), adult failure to thrive, and Chronic Obstructive Pulmonary Disease (COPD). Review of the MDS assessment for Resident #02 dated 05/27/26, revealed the resident had impaired cognition. Resident #02 was dependent on staff for activities of daily living (ADL), and the resident was dependent on hemodialysis. Review of the active care plans for Resident #02 on 06/15/26 at 3:00 P.M., revealed no comprehensive care plan for the resident being on dialysis. During an interview with on 06/15/26 at 3:04 P.M., the DON confirmed the facility failed to develop a care plan for Resident #02 being on dialysis. 3) Review of the medical record for Resident #33 revealed an admissions date of 05/07/26 with diagnoses including anxiety. Review of the MDS assessment dated [DATE], revealed Resident #33 was cognitively impaired. Review of the physician orders revealed Resident #33 had an active order dated 06/02/26 for risperidone (antipsychotic) 0.5 milligrams (mg) in the evening for other specified anxiety disorders. Review of the physician orders revealed Resident #33 had an active order dated 06/08/26 for divalproex (anti- convulsant /mood stabilizer) sodium oral tablet delayed release (DR) 250 mg once a day for seizures. Review of the active care plan for Resident #33 on 06/16/26 at 4:05 P.M., revealed there was no comprehensive care plan for Resident #33's use of an antipsychotic medications or the resident's diagnosis of seizures. During an interview on 06/16/26 at 4:10 P.M., the DON verified that Resident #33 did not have a care plan for the use of antipsychotic medication. 4) Review of the medical record for Resident #09 revealed an admissions date of 03/25/26 with diagnoses including diabetes mellitus, malnutrition, and urinary tract infection. Review of the MDS assessment dated [DATE], revealed Resident #09 was cognitively intact. Review of the physician order for Resident #09 dated 04/03/26, revealed the resident #09 had an active order for an auto adjusting Continuous Positive Airway Pressure (CPAP) daily at bedtime for sleep apnea. During an interview on 06/16/26 at 5:11 P.M. Medical Director (MD) #500 stated Resident #09 had a CPAP that he used at home prior to admissions. MD #500 verified that he ordered Resident #09 a CPAP machine. Review of the active care plan for Resident #09 on 06/16/26 at 6:15 P.M., revealed there was no comprehensive care plan related to Resident #09 utilizing a CPAP machine. During an interview on 06/16/26 at 6:16 P.M., Regional Quality Assurance Nurse #320, verified Resident #09 did not have a comprehensive care plan for CPAP machine use. Review of the facility policy titles, Care Planning - Interdisciplinary Team dated September 2013, revealed the facilities care planning/interdisciplinary team was responsible for the development of an individualized comprehensive care plan for each resident. A comprehensive care plan for each resident was to be developed within seven days of completion of resident assessment (MDS). Review of the dialysis policy titled, Care of a Resident with End-Stage Renal Disease, revealed the residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care. Further review of the policy revealed agreements between this facility and the contracted ESRD facility include all aspects of how the resident will be managed, including: how the care plan will be developed and implemented.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interview, the facility failed to ensure pain was managed as ordered, this affected one (Resident #05) out of one reviewed for pain management. The facility census was 69. Findings include: Review of the medical record of Resident #05 revealed an admission date of 04/07/26 with diagnoses of chronic obstructive pulmonary disease, Type II Diabetes Mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma, and encephalopathy. Review of the Medicare 5-Day Minimum Data Set (MDS) dated [DATE] revealed Resident #05 was cognitively intact. Resident was independent with eating, required supervision assistance with oral hygiene and wheelchair mobility, required substantial assistance with bathing, dressing, and bed mobility, and was dependent on staff assistance with toileting hygiene and transfers. Resident #05 received scheduled pain medication regimen, received as needed pain medications or was offered and declined as needed pain medication, and received non-medication intervention for pain. Further review revealed Resident #05 had pain or hurting at any time in the last 5 days, experienced pain or hurting occasionally over the last 5 days. Occasionally, over the past 5 days, pain made it hard for resident to sleep at night. Occasionally, over the past 5 days, pain limited participation in rehabilitation therapy sessions. Occasionally, over the past 5 days, pain limited day-to-day activities. Resident #05 experienced a pain intensity level of seven over the last five days. Review of the care plan dated 04/07/26 revealed Resident #05 has pain / alteration in comfort related to right below the knee amputation (RBKA) and a history of deep vein thrombosis (DVT) with interventions of administer medications as ordered and assess for effectiveness, attempt non-pharm logical interventions such as back rub, warm blanket, redirection, repositioning, monitor for effectiveness of interventions, monitor for levels of increased pain and notify physician. Review of the physician order dated 05/04/26 revealed an order for a referral to pain clinic. Interview on 06/16/26 at 1:07 P.M. with Licensed Practical Nurse (LPN) #261 confirmed the pain clinic appointment had not been made and that social services makes the appointments, but since there is not a current social worker, he would be responsible to make the appointment. Interview also confirmed he had not made the appointment for the pain clinic for Resident #05 and he is not sure which pain clinic to call. Interview on 06/16/26 at 2:08 P.M. with the Director of Nursing confirmed there was not a policy on scheduling appointments or following physician orders.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and policy review, the facility failed to act upon recommendations made by the pharmacist. This affected one (Resident #03) of five residents reviewed for unnecessary medications. The facility census was 69. Review of the medical record for Resident #03 revealed an admission date of 02/24/25 with diagnoses of schizoaffective depressed type, epilepsy and anxiety disorder. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Review of the medication regimen review (MRR) for Resident #03 on 10/01/25 revealed phenytoin level on next convenient laboratory (lab) day and every six months. There was no physician response or signature. Review of the MRR for Resident #03 on 12/01/25 revealed phenytoin and digoxin levels on next convenient lab day and every six months. There was no physician response or signature. Review of the MRR for Resident #03 on 02/01/26 revealed phenytoin and digoxin levels on the next convenient lab day and every six months. There was no physician response or signature. Review of the MRR for Resident #03 on 04/01/26 revealed phenytoin and digoxin levels on next convenient lab day and every six months. There was no physician response or signature. Review of the MRR for Resident #03 on 05/01/26 revealed Abnormal Involuntary Movement Scale (AIMS) test now and every six months. There was no physician response or signature. Review of the medical record for Resident #03 revealed an AIMS test was completed for Resident #03 on 06/15/26. Review of the MRR for Resident #03 on 06/01/26 revealed phenytoin and digoxin levels on net convenient lab day and every six months. Resident #03 lab results collected on 06/02/26 and revealed Resident #03 had a digoxin level of 1.00ng/mL and no level of phenytoin was detected. On 06/03/26 at 4:59 P.M. Director of Nursing #266 notified the nurse practitioner of lab levels and no new orders were received. Interview on 06/16/26 at 4:02 P.M. with Medical Director revealed Resident #03's, 06/02/26 lab results should have been followed up on at the time of results, and the repeat lab should not wait until December to be drawn. Medical Director stated he would order lab work every three to six months to check levels. Interview on 06/16/26 at 4:09 P.M. with Regional Quality Assurance Nurse confirmed pharmacy reviews for Resident #03 had not been reviewed or implemented. Review of the Medication Regimen Reviews policy, dated May 2019, revealed the pharmacists recommendations will be addressed timely by the physician.		

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident interview, observation, staff interview, and facility policy review, the facility failed to provide Resident #1 a therapeutic diet as ordered by the physician. This had the potential to affect 16 residents that the facility had identified with an order for a therapeutic diet. The facility census was 69. Review of Resident #1's medical record revealed an admission date of 04/04/26 with diagnoses including polyneuropathy, hypokalemia, and pneumonia. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #1 was cognitively intact. Review of the physician order dated 05/26/25 revealed Resident #1 was ordered a regular diet, mechanical soft texture, regular consistency with extra gravies, sauces, etc. to further moisten foods. Review of the care plan revealed Resident #1 was at risk for nutrition or hydration problems causing them to be at risk for malnutrition. Interventions included to provide and serve diet as ordered. Interview on 06/14/26 at 12:15 P.M. with Resident #1 revealed she has an order for a mechanical soft diet and that she is often given meals of the incorrect texture. Observation on 06/14/26 at 1:18 P.M. revealed Resident #1's lunch meal ticket stated that she received a regular diet. Further observation revealed Resident #1 was served a regular texture meal. Interview with Regional Quality Assurance Nurse #320 on 06/14/26 at approximately 1:25 P.M. verified that Resident #1's meal ticket was incorrect and the resident should not have been served a regular texture meal. Interview on 06/15/26 at 7:40 A.M. with Dietary Supervisor (DS) #273 verified that Resident #1 was served a regular diet for lunch on 06/14/26. DS #273 stated he was unaware of Resident #1 having an order for a mechanical soft diet and verified the meal ticket was not updated when she had a diet change to mechanical soft. Review of the facility policy titled, Therapeutic Diets dated October 2017 revealed therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences.		

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews and staff interviews, the facility failed to ensure residents signing binding arbitration agreements understood the agreement. This affected two residents (#48 and #62) of five residents reviewed for arbitration. The facility census was 69. 1. Review of the medical record for Resident #48 revealed an admission date of 11/04/25 with diagnosis of non-Alzheimer's dementia. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of seven, indicating severe cognitive impairment. Review of the Arbitration Agreement revealed the agreement was signed by Resident #48 on 11/19/25 at 1:17 P.M. Interview on 06/16/26 at 8:25 A.M. with Admissions Director #203 confirmed Resident #48 resided in the memory care. Interview on 06/16/26 at 8:45 A.M. with Regional [NAME] President of Operations confirmed memory care residents should not be signing binding arbitration agreement. 2. Review of the medical record for Resident #62 revealed an admission date of 09/17/25 with diagnoses of non-Alzheimer's dementia and hypertension. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of seven, indicating severe cognitive impairment. Review of the Arbitration Agreement revealed the agreement was signed by Resident #62 on 09/19/25 at 4:20 P.M. Interview on 06/16/26 at 8:25 A.M. with Admissions Director #203 confirmed Resident #62 resided in memory care. Interview on 06/16/26 at 8:45 A.M. with Regional [NAME] President of Operations confirmed memory care residents should not be signing binding arbitration agreement.		