STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365686	A. Building B. Wing	03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Columbus Healthcare Center	4301 Clime Road North Columbus, OH 43228

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review, the facility failed to maintain clean and sanitary bed curtains. This affected one (Resident #45) of three residents reviewed for environment. The facility census was 95 residents.Findings include:Review of Resident #45's medical record revealed an initial admission date of 11/08/24 and a readmission date of 02/20/26. Resident #45's diagnoses included type 2 diabetes mellitus with hyperglycemia, long term (current) use of insulin, chronic obstructive pulmonary disease unspecified, moderate protein-calorie malnutrition, epilepsy unspecified not intractable without status epilepticus, presence of right artificial shoulder joint, acquired absence of right leg above knee, polyneuropathy unspecified, anemia unspecified, and generalized anxiety disorder. Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #45 was cognitively intact. Observation of Resident #45's bed curtain on 03/16/26 at 10:31 A.M. revealed three dark red stains splattered on the curtain. The largest stain measured approximately one centimeter (cm). The other two stains measured approximately 0.5 cm. Further observation of Resident #45's bed curtain also revealed linear black stains. Interview with Resident #45 on 3/16/26 at 10:31 A.M. revealed the resident requested the bed curtain be cleaned, but the facility never cleaned the curtain. Interview with Certified Nurse Aide (CNA) #249 on 03/16/26 at 10:56 A.M. confirmed stains were present on Resident #45's bed curtain. Interview with Risk Management #366 on 3/23/26 at 3:28 P.M. revealed the facility does not have an environment policy. Risk Management #366 confirmed environmental concerns would be included in the facility ?Resident Rights' policy as residents have the right to a safe, clean, home-like environment. Review of the facility policy ?Resident Rights' undated revealed residents will be treated with dignity and respect. Dignity included providing safe and secure housing.This deficiency represents non-compliance investigated under Complaint Number 2631443.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and review of facility policy, the facility failed to provide nail care for Residents #66, and #88 who were dependent on staff for care. This affected two residents (#66 and #88) of seven residents reviewed for activities of daily living. The facility census was 95.Findings include: 1. Review of Resident #66's medical record revealed an admission date 07/25/25. Resident #66's diagnoses included chronic obstructive pulmonary disease unspecified, repeated falls, dysphagia following cerebral infarction, unspecified protein-calorie malnutrition, essential (primary) hypertension, dysphagia oropharyngeal phase, alcohol use unspecified uncomplicated, anxiety disorder unspecified, and depression unspecified. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #66 was cognitively intact. Resident #66 was dependent for putting on and taking off footwear. Observation of Resident #66 on 03/16/26 at 12:22 P.M. revealed long, jagged toenails. Interview with Resident #66 on 03/16/26 at 12:22 P.M. revealed staff do not provide toenail care. Interview with Certified Nurse Aide (CNA) #116 confirmed Resident #66 toenails were long and jagged. Further interview with CNA #116 revealed the CNA was uncertain if permitted to trim toenails in the facility. Interview with Director of Social Services #129 on 03/18/26 at 12:13 P.M. revealed Resident #66 declined podiatry care on 01/23/26. Interview with Director of Nursing (DON) on 03/23/26 at 1:45 P.M. confirmed CNAs can trim toenails if the resident does not have a diagnosis of diabetes. However, further interview with the DON confirmed, since Resident #66's toenails were in such poor condition, the resident should be re-referred to podiatry for toenail care. Review of the facility job description 'Certified Nurse Aide' revealed it was the responsibility of the Certified Nurse Aide to provide personal care functions to residents. Review of facility policy 'Routine Resident Care' undated revealed routine daily care will be provided to residents. 2. Review of Resident #88's medical record revealed an admission date of 09/19/24 with diagnoses including anoxic brain damage, chronic obstructive pulmonary disease, dysphagia, contractures of right and left hand, attention-deficit hyperactivity disorder, moderate protein-calorie malnutrition, psychoactive substance abuse, anxiety disorder, and cognitive communication deficit. Review of Resident #88's comprehensive MDS assessment dated [DATE] revealed the resident had severely impaired cognition. He was dependent for personal hygiene and bathing. Review of Resident #88's plan of care revised 02/26/26 revealed a self-care performance deficit related to anoxic brain injury, contractures, fearful during care, and will grab at and hold onto staff (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	during care. Interventions included lids on hot beverages, placing splints as ordered, the resident was dependent for personal hygiene. Review of Resident #88's plan of care dated 10/28/24 revealed the resident had bilateral hand contractures and impaired functional range of motion. Interventions included administering medications as ordered, monitoring for increase in pain, monitoring skin condition under splint upon removal and report any areas of concern, placing splints as ordered, therapy as ordered. Review of Resident #88's medical record revealed no documentation indicating when his nails were cleaned or cut. Observation on 03/16/26 at 10:15 A.M. and 1:45 P.M. of Resident #88 revealed his right hand was contracted with his thumb and index finger extended. The nails observed on his right hand and all the nails on his left hand were observed to be long (approximately one centimeter past his fingertips) and had a dark brown substance underneath them. Observation on 03/16/26 at 3:30 P.M. of Resident #88 revealed his fingernails remained long and dirty. He declined to open his contracted hand or have assistance opening it. Interview on 03/16/26 at 3:30 P.M. with CNA #396 verified the condition of Resident #88's nails. She reported a service came in to take care of residents nails, she then indicated she thought hospice took care of Resident #88's nails. CNA #396 went to confirm with Registered Nurse (RN) #470, who reported that she thought hospice was responsible. CNA #396 then spoke to the Director of Nursing (DON) who reported the CNAs were responsible for nail care. This deficiency represents non-compliance under Complaint Numbers 2631443 and 2579770.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility policy, the facility failed to ensure a midline dressing was changed as ordered. This affected one (Resident #53) of one resident reviewed for intravenous access line care. The facility census was 95 residents.Findings include:Review of Resident #53's medical record revealed the resident was admitted to the facility on [DATE] and had diagnoses that included cellulitis of the left lower limb, chronic diastolic (congestive) heart failure, other specified chronic obstructive pulmonary disease, and obesity class Review of the Minimum Data Set (MDS) assessment, dated 01/05/26, revealed Resident #53 was cognitively intact. Review of Resident #53's Midline Insertion Record completed 02/27/26 at 12:05 P.M. revealed a midline catheter (a vascular access device used for intravenous therapy) was placed in the left cephalic vein (a vein located in the left upper arm) on 02/27/26. Further review of Resident #53's Midline Insertion Record revealed a transparent dressing was placed over the midline catheter. Review of Resident #53's order dated 03/03/26 revealed an order to measure external catheter length with each dressing change ordered for every day shift on Fridays and to change the needleless connector with the site change every week ordered for every day shift on Fridays. Review of Resident #53's Treatment Administration Record (TAR) for March 2026 revealed the external catheter length was measured with each dressing change and the needleless connector was changed with each site change on 03/06/26 and on 03/13/26. Observation of Resident #53's midline insertion site on 03/16/26 at 9:08 A.M. revealed a dressing covering the site dated 02/27/26. Interview with Registered Nurse (RN) #470 on 03/16/26 at 9:21 A.M. confirmed the dressing covering the midline insertion site was dated 02/27/26 and should have been changed. Review of facility policy 'PSG Infusion Intravenous (IV) Access Line Maintenance Protocol' effective 04/15/23 revealed a transparent dressing covering a midline catheter should be changed 24 hours after insertion, then weekly and as needed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, record review, and review of facility policy, the facility failed to have interventions in place to prevent falls for Residents #52, #15, #97, #103, and #94. Additionally, the facility failed to complete a thorough investigation following a fall for Resident #88. This affected six residents (#52, #15, #97, #88, #103, and #94) of 11 residents reviewed for falls. The facility census was 95 residents.Findings include:1.Resident #52 was admitted [DATE] and has diagnoses that include chronic obstructive pulmonary disease, severe protein-calorie malnutrition, and dysphagia. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] indicated the resident used a wheelchair for mobility and has severe cognitive impairment. Review of the facility incident and accident log revealed Resident #52 suffered falls on 12/24/25 and 01/02/26. Review of the medical record for Resident #52 revealed an order for non-skid strips on the floor near bed for recurrent falls from bed ordered on 12/24/25. Further review of Resident #52's care plan revealed an intervention of fall mat to both sides of bed for resident at risk of falls initiated on 12/25/25 and intervention for non-skid strips to floor near bed initiated 02/24/26. Observation of the Resident #52's room was conducted on 03/17/26 at 12:49 P.M. There were no non-skid floor strips found near the resident's bed and no fall mats placed at bedside. Interview with Licensed Practical Nurse (LPN) #161 was conducted on 03/17/26 at 12:49 P.M. LPN #161 confirmed that there were no non-skid strips and no fall mats near the bed in Resident #52's room. 2. Review of Resident #15's medical record revealed an original admission date of 04/24/25 and a readmission date of 02/08/26. Resident #15's diagnoses included limitation of activities due to disability, radiculopathy lumbar region, unspecified convulsions, syncope and collapse, muscle wasting and atrophy not elsewhere classified multiple sites, unsteadiness on feet, chronic pain, muscle weakness (generalized), and need for assistance with personal care. Review of the MDS dated [DATE] revealed Resident #15 was cognitively intact and independent for eating, oral hygiene, toileting hygiene, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. Resident #15 required substantial/maximal assistance to shower/bathe self. Review of Resident #15's progress notes dated 02/26/26 at 05:43 A.M. revealed the resident was found lying on the floor. Review of Resident #15's Interdisciplinary Team (IDT) Follow Up note dated 02/27/26 at 10:49 A.M. revealed the post-fall intervention put into place was nonskid strips to the floor. Review of Resident #15's risk for falls care plan initiated 10/25/23 and revised on 06/02/25 did not reveal an intervention of nonskid strips to the floor. Further review of Resident #15's care plan revealed an intervention for a visual reminder to ask for assistance when getting out of bed that was (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	initiated on 06/10/25 and revised on 03/12/26. Observation of Resident #15's room on 03/16/26 at 9:30 A.M. revealed nonskid strips were not on the floor of the resident's room and the visual reminder to ask for help was not observed in the room. Observation of Resident #15 room on 03/16/26 at 3:00 P.M. revealed nonskid strips were not on the floor of the resident's room and the visual reminder to ask for help was not observed in the room. Observation of Resident #15 on 03/17/26 at 4:05 P.M. revealed nonskid strips were not on the floor of the resident's room and the visual reminder to ask for help was not observed in the room. Interview with Registered Nurse (RN) #470 on 03/17/26 at 4:18 P.M. confirmed nonskid strips were not on the floor of Resident #15's room. Interview with LPN #422 on 03/18/26 at 7:49 A.M. revealed a visual reminder to ask for help would hang on the wall near Resident #15's bed and in the bathroom. Further interview LPN #422 confirmed that the visual reminder to ask for help was not in place for Resident #15. 3. Review of the medical record for Resident #97 revealed an admission on [DATE]. Diagnoses included cerebral infarction, hemiplegia and hemiparesis, traumatic hemorrhage of the cerebrum, heart disease and alcohol abuse. Review of the admission MDS completed on 01/04/26 revealed the resident was cognitively intact. He required one person to assist with activities of daily living. Further review of the medical record for Resident #97 revealed he was found on the floor on 02/12/26 at 2:15 P.M. A full investigation was completed, and it was determined Resident #97 was left in his room in his wheelchair after his therapy session. He was sitting in his wheelchair and slid out of it onto the floor. It was an unwitnessed fall with no injuries. The Interdisciplinary team reviewed the fall and added a preventative intervention of Dycem to his wheelchair. Observation and interview on 03/19/26 at 11:00 A.M. of Resident #97 in the therapy department confirmed he did not have Dycem on his wheelchair seat to prevent him from sliding out of it. Therapist #364 and #362 verified there was no Dycem to Resident #97's wheelchair. Interview with Therapist #362 on 03/19/26 at 11:15 A.M. confirmed she was the therapist who placed the Dycem on his wheelchair after his fall and did not know why it was not on it. 4. Review of Resident #88's medical record revealed an admission date of 09/19/24 with diagnoses including anoxic brain damage, chronic obstructive pulmonary disease, dysphagia, contractures of right and left hand, attention-deficit hyperactivity disorder, moderate protein-calorie malnutrition, psychoactive substance abuse, anxiety disorder, and cognitive communication deficit. Review of Resident #88's comprehensive MDS 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition. He was dependent on staff for rolling. Review of Resident #88's plan of care dated 08/21/25 revealed the resident was at risk for falls related to mobility, gait problems, and medications. Interventions included assessing risk for falls on admission, educating resident or resident representative, encouraging and assisting resident to up to (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	chair before dinner, ensuring resident is wearing appropriate nonskid footwear, and ensure room is free from accident hazards. Review of Resident #88's plan of care revised 02/26/26 revealed a self-care performance deficit related to anoxic brain injury, contractures, fearful during care, and will grab at and hold onto staff during care. Interventions included lids on hot beverages, placing splints as ordered, the resident was dependent for toileting hygiene, bathing, personal hygiene, and rolling in bed. Review of Resident #88's progress note dated 02/27/26 at 7:07 P.M. revealed the resident was lowered to the floor during activity of daily living care by the certified nursing assistant (CNA). The resident received a skin tear to the right side of his back during this. Review of Resident #88's fall investigation dated 02/27/26 revealed the conclusion of the event was entered on 03/01/26. It was indicated that the hospice aide was providing care to Resident #88 when they fell out of bed. The resident was assisted to the floor by the CNA, the suspected root cause was the air mattress and turning the resident. The investigation did not identify why the resident needed to be lowered to the floor, who lowered them to the floor, and how he obtained a skin tear. Interview on 03/18/26 at 3:00 P.M. with the Director of Nursing (DON) revealed both a hospice aide and a facility CNA had been present for Resident #88's fall. She reported the resident was totally dependent on care and 'could' have rolled out of bed when the cloth underneath him had been pulled. She reported she had witness statements. Review of the witness statement provided on 03/19/26 revealed the statement was by Unit Manager #365. It indicated the nurse reported to them that the hospice aide was providing a bed bath and our staff was in the room when Resident #88 was being turned, staff CNA controlled a fall from the bed and the resident received a skin tear. Interview on 03/19/26 at 10:51 A.M. with the Director of Nursing (DON) revealed the staff present in the room were contradicting each other on what happened. The only witness statement she had was by Unit Manager #365. She verified it was unclear what happened and how he obtained the skin tear. The DON verified a thorough investigation was not completed. 5. Review of Resident #103's medical record revealed an admission date of 03/04/26 major depressive disorder, borderline personality disorder, unspecified mood disorder, convulsions, personal history of other mental and behavioral disorders, conversion disorder with seizures or convulsions, anxiety disorder, and fibromyalgia. Review of Resident #103's comprehensive MDS 3.0 assessment dated [DATE] revealed the resident had intact cognition. Review of Resident #103's plan of care dated 03/06/26 revealed the resident was at risk for falls related to being a new admission, potential medication side effects, and a history of seizures. Interventions included assessing risk for falls, education, ensuring the residents room is free from potential hazards, ensuring bed locks were engaged, medication review, placing call bell in reach, and added 03/09/26 fall mats. Review of Resident #103's progress note dated 03/08/26 revealed the resident fell from bed during seizures and was sent to the hospital. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #103's interdisciplinary fall follow up dated 03/09/26 revealed on 03/08/26 at 6:55 P.M. the resident had been observed with seizure activity on the floor at bedside. The intervention was to put fall mats in place to both sides of the bed. Observation on 03/16/26 at 11:00 A.M. and on 03/19/26 at 8:40 A.M. revealed Resident #103 was in bed and fall mats were not in place. Interview on 03/19/26 at 8:40 A.M. with the Director of Nursing (DON) revealed the intervention for Resident #103's first fall was a fall mat. The DON verified Resident #103's fall mat was not in place at that time. 6. Review of the medical record for Resident #94 revealed a readmission date of 12/10/25 with diagnoses of, but not limited to, acquired absence of left leg above knee, polyneuropathy, muscle weakness, and muscle wasting atrophy. Review of Resident #94's Brief Interview of Mental Status revealed a score of 15 indicating the resident was cognitively intact. Review of the progress note dated 02/09/26 revealed the resident had gone out of the facility with a company driver to attend dialysis and while going toward the van the resident fell forward out of the wheelchair and hit his head. According to the progress note staff were reported to have gotten the resident up from the floor and transferred Resident #94 back into his wheelchair, transported him back inside the facility, and notified the nurse. The nurse was reported to have completed a body assessment, neurological checks, and range of motion to extremities. There were no noted changes in range of motion, and a small abrasion was noted to the right leg below the knee and vital signs were normal. Per the progress note the facility contacted a 24/7 clinical coverage provider and the resident was assessed via video and orders were placed for x-ray due to the resident complaining of right shoulder and cervical spine pain. Review of the Interdisciplinary Team (IDT) Fall Follow-up dated 02/10/26 revealed Resident #94 was being transferred in a wheelchair out of the facility when their right leg was caught up in the wheel and the resident fell forward. The IDT Fall Follow-up identified the cause of the fall to be the resident needed their right food pedal placed on the wheelchair and initiated a post fall intervention of the right food pedal to be put in place when the resident was being transported via wheelchair. Interview with Therapy Manager (TM) #364 on 03/18/26 at 3:45 P.M. revealed a resident with a wheelchair is always given foot pedals. TM #364 reported a resident can refuse the foot pedals but if they do their foot pedals are returned to therapy or kept in the residents' room, and the refusal would be noted in the residents' chart. TM #364 revealed Resident #94 always used foot pedals when in their wheelchair, including coming to and from therapy and when exiting the building. Interview with the Director of Nursing (DON) on 03/19/26 at 11:25 A.M. confirmed Resident #94's fall was due to his foot going underneath the wheel of the wheelchair while the dialysis company was transporting him from the facility to the van for dialysis. DON confirmed the resident did not have the right foot pedal on his wheelchair when leaving for dialysis and this was implemented as a care plan intervention post fall. Additional interview with TM #364 on 03/23/26 at 11:15 A.M. revealed the resident should have always had the foot pedals on, especially when leaving the facility for dialysis. TM #364 revealed (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #94 could not take the pedal off themselves. TM #364 also confirmed the resident could not self-propel and therefore the pedals would not be taken off for him to do so. Review of the facility policy titled, Fall Prevention and Management, not dated, revealed the facility would identify risk factions that can minimize the potential for falls. The policy further revealed the facility would obtain information about the resident from other sources when identifying their risk for falls including but not limited to physical assessments, diagnoses, and the residents current Activities for Daily Living (ADL) status. Further review revealed a fall investigation should begin once the resident was safely transferred following a fall. The resident should be asked what they were doing when they fell, even if they have dementia, and witnesses should be identified and asked to write a written statement immediately. In order to put in a post fall intervention the facility was to attempt to identify why the resident fell. During the interdisciplinary team review the team should discuss the fall, potential causes, interventions in place, and a deep root cause investigation should be discussed. This violation represents noncompliance investigated under complaint 2647719, 2595291, and 2795028.

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the social service director job description, the facility failed to timely arrange and follow up on guardianship for Resident #78 according to the expert evaluation. This affected one resident (#78) of one resident reviewed for guardianship. The facility census was 95.Findings include: Review of Resident #78's medical record revealed an admission date of 03/22/23 with diagnoses including chronic myeloid leukemia, chronic obstructive pulmonary disease, chronic heart failure, aphasia, dementia, epilepsy, spondylosis, gout, and depression. Review of Resident #78's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had moderately impaired cognition. Review of Resident #78's hospital social work Discharge summary dated [DATE] revealed the social worker had spoke to the facility about starting guardianship and they were in agreement. Review of Resident #78's statement of expert evaluation completed 03/05/25 revealed it concluded that guardianship should be established or continued. Review of Resident #78's progress note dated 04/24/25 revealed the social worker submitted a referral to [NAME] County Probate Investigator following the completed expert evaluation. Review of Resident #78's progress note dated 07/08/25 revealed the social worker sent correspondence to [NAME] County Probate to inquire about services and the referral sent by the previous social worker. The social worker was waiting on a response and would update with facility team and discuss next steps. Review of Resident #78's medical record from 07/09/25 to 03/23/26 revealed no additional documentation about Resident #78 obtaining a guardian. Interview on 03/19/26 at 12:39 P.M. with Director of Social Services #129 revealed she believed the guardian process had been delayed because the resident had a house nobody had been aware of. She did not know if this had been followed up on since her last note on 07/08/25, and would have to check. Further interview on 03/23/26 at 9:50 A.M. revealed she had no further information. She had submitted information for guardianship but had not heard anything and had not followed up. Interview on 03/19/26 at 9:55 A.M. and 12:40 P.M. with Regional Business Office Manager #393 revealed she was unaware of any housing situation that would prevent guardianship and has asked the social worker to follow up. Review of the position description for Social Service Director, dated June 2019, revealed the position provided planning, assessing, coordinating and implementing services to enhance each residents social and psychosocial well being and assure that care standards are met. The social service director was to perform all duties involved in resident advocacy. They were to perform applications for supplementary services to be used while in the facility. This deficiency represents non-compliance under Complaint Number 2749140