STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365694	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hopewell Grove Rehabilitation and Healthcare	60 Marietta Road Chillicothe, OH 45601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, resident and staff interviews, wound nurse practi-tioner interview, review of wound notes, hospital records, wound clinic records, review of the information from the National Pressure Injury Advisory Panel (NPIAP), and policy re-view, the facility failed to ensure the physician ordered treatments were completed as di-rected and failed to ensure interventions were implemented to prevent the development of, worsening of and promote the healing of avoidable facility acquired stage IV and un-stageable pressure ulcers with the development of osteomyelitis (a serious infection and inflammation of the bone or bone marrow, typically caused by bacteria (most commonly Staphylococcus aureus) or fungi. It occurs when infections spread from nearby tissue, open wounds, or the bloodstream, causing symptoms like localized bone pain, swelling, fever, and redness) for Resident #72. Resident #72 was at risk for pressure ulcer [NAME]-opment and dependent on staff for activities of daily living (ADLs) including transfers, bed mobility, turning and repositioning and toileting and a known left ischium stage IV pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle. Slough, a yellowish, stringy dead tissue or eschar, a layer of dead, dry tissue that forms a dark leathery scab over the ulcer may be present on some parts of the wound bed. Often includes undermining and tunneling). This resulted in Immediate Jeopardy for Resident #72 when the facility failed to implement effective interventions to prevent the development of and adequately treat avoida-ble facility acquired unstageable (full-thickness skin and tissue loss in which the extent of the tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar) pressure ulcers to the right ischium and the bilateral buttocks (sacrum). On 08/27/25, Resident #72 requested to go to the emergency room due to laboratory blood results obtained due to monitoring of the sacrum pressure ulcer on 08/26/25 resulting in a higher white blood cell count 18.6 (K/cm) (high white blood cell count can indicate a range of conditions including infections, inflammation, injury and immune system disorders) compared to results obtained on 08/21/25 of 14.9. Resident #72 was admitted to the hos-pital with a stay of 08/27/25 through 09/01/25 with a diagnosis of osteomyelitis of the sa-cral stage IV pressure ulcer requiring intravenous antibiotics and ongoing treatment for the left and right ischium pressure ulcers. In addition, a concern that did not rise to the level of Immediate Jeopardy but did rise to the level of Actual Harm was identified on 01/12/26 for Resident #6, who was admitted on [DATE], (at risk for pressure ulcer development and altered skin integrity) when the facil-ity failed to implement pressure ulcer prevention strategies and the resident developed an in-house unstageable pressure ulcer. In addition, a concern that did not rise to the level of Immediate Jeopardy or Actual Harm was identified related to the facility's failure to ensure pressure ulcer prevention measures and care were in place for Resident #2.This affected three (Residents #2, #6 and #72) of three residents reviewed for pressure ulcer care. The facility census was 74.On 02/17/26 at 2:56 P.M. the Administrator, [NAME] President of Operations #1051, [NAME] President of Clinical Services (VPCS) #1029, Regional Director of Clinical Services (RDCS)#1050, and Director of Nursing (DON) #1057 were notified Immediate Jeopardy began on 08/27/25 when the facility failed to provide correct treatment orders, necessary interventions and notification to the medical provider of abnormal laboratory results timely for Resident #72 to prevent avoidable facility acquired pressure ulcers to the (continued on next page)

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

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	right ischium and sacrum with the declining of the unstageable sacrum pressure ulcer resulting in hospitalization on 08/27/25 for osteomyelitis. Resident #72 returned to the facility on [DATE] with continued inaccurate treatments and necessary interventions to promote healing of the left and right ischium and sacrum pressure ulcers. Resident #72 continued to have the three areas of pressure ulcers as of 02/10/26.The Immediate Jeopardy was removed on 02/19/26 when the facility implemented the following corrective actions: -On 02/17/26 immediately after being notified at 3:00 P.M. Licensed Practical Nurse (LPN) #1077 initiated skin inspection on all 79 current residents with verifying interventions. All residents were assessed by the LPN #1077 by 10:00 P.M. with treatments initiated for new identified areas. All inspections were completed by LPN #1077. The following residents with new areas identified were: Resident #11 with a loose toenail and a new order for a protective dressing, Resident #24 with a blister to the abdomen and a new treatment order of non-stick pad, Resident #55 with an abrasion to a knee and a new treatment of a bordered foam. -On 02/17/26 immediately after being notified at 3:00 P.M., the current six residents (Residents #2, #3, #6, #61 #72, and #90) with pressure injuries treatment orders were audited by the RDCS #1050. The audits were to verify current orders in the electronic medical record (EMAR) match the order provided by the Wound Consultant Nurse Practitioner (WCNP) #1054. The RDCS #1050 audited wound note visits from the wound clinic visit on 02/17/26 for Resident #72 and verified orders. Resident #72 is the only resident that sees an outside wound clinic at this time. -On 02/17/26 at 5:15 P.M. the facility completed an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting with Medical Director #1028 via phone with attendance of: Administrator, DON #1057, LPN #1077, VPO # 1051, Activity Director #1073, Dietary Manager # 1074, Admissions #1075, Social Service Designee #1079, Medical Records #1072, Maintenance Director #1076, and Housekeeping Director #1080. The meeting discussed and addressed the Immediate Jeopardy and education was initiated post Immediate Jeopardy meeting with the nursing department.-On 02/17/26 the DON #1057 began education to facility nurses and Certified Nurse Assistants (CNA) at 3:30 P.M. CNA and nurse education included skin prevention, daily skin care, skin inspection, skin inspection, skin inspection, documentation of refusal nutrition & hydration, and reporting & documentation. Nurses were educated on treatment implementation when skin alteration identified, ensuring interventions in place, documentation of refusals, following orders given by the physician or nurse practitioner and reporting abnormal labs same day as resulted with documentation. -On 02/17/26-The DON #1057 verbally provided education to the following staff: eight LPNs, 17 CNAs, and two Registered Nurses (RN) on 02/17/26 by 10:00 P.M. Any staff member that did not receive the education at this time, messages were left and unable to speak with, will have verbal education prior to next scheduled shift. At 6:30 P.M., a communication message was sent to all staff that have not received education to contact the DON #1057.-On 02/17/26 education was completed by the DON #1057, at 10:30 P.M. Staff (5 LPNs and 22 CNAs) that a message was left for will be educated prior to next scheduled shift.-On 02/17/26 the clinical management team, DON #1057, LPN #1077 and LPN #1078 were educated by the RDCS #1050 on auditing skin prevention, interventions, order implementation, and documentation. The education was completed at 3:30 P.M. DON #1057 will be completing pressure wound measurements and assessments with the addition of MDS RN #1071, as back up to DON #1057 for wound assessment. -On 2/17/26 VPCS #1029 and the RDCS #1050 reviewed Skin and Wound Policy for accuracy and ensure policy meets regulatory guidelines.-On 2/18/26 at 4:00 P.M. education initiated by the clinical management team, DON #1057, LPN #1077 and LPN #1078 was given to all licensed nurses on changes in resident skin integrity related to decline and interventions and notification of labs to medical profession, to be completed by 7:00 P.M. on 2/18/26. - On 02/19/26 the RDCS #1050 completed an audit on wound evaluations initiated since 02/17/26 wound rounds to identify new skin areas and verified that all new skin issues had new treatments and discovered: Resident #14 with a skin tear and a new treatment of xeroform and kerlix, Resident #6 with a skin tear to left shin with a treatment of xeroform and Kerlix, Resident #22 with two new diabetic ulcers with a treatment of (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	xeroform and kerlix and Resident #94 with new pressure area to sacrum and treatment in place of chamosyn (a multi-purpose, paraben-free, and nourishing barrier ointment formulated with Zinc Oxide, Menthol , Aloe, and Manuka Honey to protect, soothe, and treat skin irritated by moisture, incontinence, or fecal/vaginal fistulas. It is designed to create a protective barrier while reducing inflammation) and leave open to air (LOTA). -Beginning on 02/19/26 DON #1057/designee will audit all new admissions orders for 30 days to ensure skin treatments were implemented as ordered. If the DON #1057 is not available, the RDCS #1050 will audit. The audit will verify each identified area has a treatment in the EMAR and will be completed by DON #1057 or LPN #1077 or LPN #1078 in the DON #1057's absence.-Beginning on 02/19/26 DON #1057/designee will audit all residents seen by wound consultants and outside wound clinics weekly x 4 weeks for resident's treatment orders to verify they match the wound consultant orders, if seen by wound consultant. The audit will verify the orders were implemented timely by the facility nurse. - On 02/19/26 at 3:00 P.M. DON #1057 educated MDS RN #1071 on auditing skin prevention, interventions, order implementation, and documentation.-Beginning on 02/24/26 all audit results will be reported to QAPI for review weekly x four weeks.Although the Immediate Jeopardy was removed on 02/19/26, the facility remains out of compliance at a Severity Level 3 (actual harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective action and monitoring to ensure on-going compliance. Findings include: 1.Record review revealed Resident #72 was admitted on [DATE]. Diagnoses included left buttock stage 4 pressure ulcer, paraplegia, generalized anxiety disorder, major depressive disorder, neuromuscular dysfunction of bladder. Review of the hospital stay documents dated 06/18/25 through admission to the facility on [DATE] for Resident #72 revealed a left ischium stage IV pressure ulcer with osteomyelitis with orthopedic surgery recommending follow up care with a tertiary center for potential debridement and plastic surgery consult wound coverage/closure. Documentation did discuss a wound vac for the left ischium Stage IV pressure ulcer, but no discharge wound care treatments were noted. This resident also had a suprapubic catheter and an ostomy. There was no evidence that the orthopedic surgery recommendation of follow up care with a tertiary center for potential debridement and plastic surgery consult wound coverage/closure was completed. Review of the progress note dated 07/03/25 12:30 P.M. for Resident #72 revealed the resident was admitted to the facility. Review of the admission evaluation dated 07/03/25 at 12:30 P.M. for Resident #72 revealed a mental status of knows own limits, a skin impairment of pressure (no location, assessment and measurement), a Braden Scale for Predicting Pressure Sore Risk score of 15 indicated mild risk on a scale of 6 (high risk) to 23 (no risk) and a two person assist with bed mobility. Review of the wound evaluation for Resident #72 dated 07/04/25 at 2:06 A.M. by LPN #1027 revealed a left buttock stage IV pressure ulcer measured 3 centimeters (cm) by 2 cm by 2 cm with no description of the wound bed. Review of the physician order for Resident #72 dated 07/04/25 at 2:15 A.M. by LPN #1027 revealed a treatment for the left buttock, wash wound, apply wound vac every Monday, Wednesday and Friday. Review of the plan of care dated 07/04/25 for Resident #72 revealed impaired skin integrity with no interventions to assist to turn and reposition, float/elevate heels while in bed and a low air loss (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	mattress. Review of the admission evaluation for Resident #72 dated 07/07/25 by Family Nurse Practitioner (FNP) #1052 revealed the only skin impairment was a left ischium pressure ulcer. Per nursing documentation, no noted concerns or changes for care since admission. Review of the Treatment Administration Record (TAR) for Resident #72 revealed on 07/04/25 and 07/07/25, no treatment was signed off as completed for the left buttock pressure ulcer wound vac. Review of the physician order for Resident #72 dated 07/07/25 at 2:53 P.M. by RN #5555 revealed bilateral heel boots as preventative measure every day and night shift. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #72 was moderately cognitively impaired. Resident #72 required substantial/maximal assistance with shower/bathe self and total dependence with bed mobility, transfers, and toilet hygiene. Resident #72 had a pressure injury and was not on a turning/repositioning program. Review of the wound consult visit notes revealed Resident #72 was seen by Wound Certified Nurse Practitioner (WCNP) #1055 on 07/09/25. Upon assessment, the wound vac was not connected to the resident, and the resident was a full two person assist for activities of daily living. Recommended for follow up with a plastic surgeon to discuss debridement and wound closure. The facility documented a left buttock, but it is a left ischium unstageable pressure ulcer measuring 2.6 cm by 1.8 cm by 1.2 cm and wound bed description 40 percent granulation and 60 percent slough. Exposed tissues included dermis, subcutaneous and adipose. Required debridement. A treatment plan of cleanse with wound cleanser, apply Hydrogel, Calcium Alginate with Silver to the base of the wound and cover with bordered foam daily. A new facility acquired area of a left heel unstageable pressure ulcer measured 1 cm by 0.6 cm by no depth. Required debridement. A treatment plan of cleanse with wound cleanser, apply skin prep to the base of the wound, secure with bordered foam and change twice a day. Preventative measures to include but not limited to turning/repositioning per protocol and floating heels while in bed with the use of heel boots. Review of the nutritional risk assessment dated [DATE] at 2:00 P.M. by Dietician #1111 for Resident #72 revealed she was bedridden, and had a skin condition of a pressure ulcer or multiple areas that are at least a Stage III/IV/unstageable with admitted left buttock pressure ulcer and now a left heel unstageable pressure ulcer. Recommend starting Prostat (a protein supplement) 30 milliliters twice a day to assist with wound healing and will continue to monitor and follow up as needed. No acute nutrition concerns at that time. There was no documentation Resident #72 refused care or was non-compliant with care including turning and repositioning. Review of the plan of care initiated on 07/16/25 for Resident #72 revealed at risk for impaired skin integrity related to confined to bed all or most of the time, paraplegia, and requires staff assistance to reposition with interventions including but not limited to assist resident with turning and repositioning as needed and if resident refuses interventions, encourage compliance. Review of the wound consult visit notes revealed Resident #72 was seen by WCNP #1123 on 07/16/25. The left ischium measured at 3.5 cm by 2.5 cm by 2.9 cm and the left heel unstageable wounds were stable. Wound bed description 70 percent granulation and 30 percent slough with (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	exposed tissues now including muscle/fascia. Required debridement. A new treatment plan of cleanse with wound cleanser/normal saline, apply medical grade honey, Calcium Alginate to the wound bed and secure with boarded foam daily. The left heel unstageable pressure ulcer no concerns/changes to treatment. A new area of bilateral buttocks gluteal dermatosis (a common, underdiagnosed skin condition in the elderly, characterized by brownish, scaly, and thick (lichenified) plaques on the buttocks, (primarily caused by chronic pressure and friction from prolonged sitting) partial thickness measuring 4 cm by 2.5 cm by 0.1cm. Wound base 100 percent epithelial with peri wound intact and erythema. A treatment plan of cleanse with soap and water, apply Zinc Oxide, but prefer Triad paste (WCNP #1123 preferred the Triad paste) to the base of the wound and leave open to air every shift and as needed. Review of the physician orders dated 07/16/15 through 07/22/25 for Resident #72 revealed no treatment order for the bilateral buttocks gluteal dermatosis and no new treatment order for the left ischium unstageable pressure ulcer. (There was no order placed in the electronic medical record at all for the bilateral buttocks gluteal dermatosis). Review of the TAR for Resident #72 dated 07/16/25 through 07/22/25 revealed no treatment for the bilateral buttocks gluteal dermatosis and the incorrect treatment for the left ischium unstageable pressure ulcer. Review of care visit for Resident #72 dated 07/18/25 by FNP #1052 revealed will add an air mattress to her bed to help prevent further pressure ulcers and improve comfort. Review of the wound consult visit notes revealed Resident #72 was seen by WCNP #1055 on 07/23/25. The left ischium unstageable pressure ulcer worsened. it now measured 3.2 cm by 3 cm by 2.9 cm and had undermining from 6 o'clock to 12 o'clock at 3.2 cm. The wound bed description was 60 percent granulation and 40 percent slough with continued exposed muscle/fascia. Required debridement. A new treatment plan of cleanse with wound cleanser/normal saline, apply Calcium Alginate and Zinc Oxide to the base of the wound, secure with bordered foam daily. The left heel unstageable pressure ulcer no concerns/changes to treatment. The bilateral buttocks gluteal dermatosis partial thickness had worsened. It now measured 12 cm by 7 cm by 0.1 cm. Wound base 100 percent epithelial and peri wound intact, erythema and fragile with light amounts of serosanguineous exudate. A new treatment plan of cleanse with soap and water, apply medical grade honey, xeroform, Zinc Oxide to the peri wound to the base of the wound, secure with an abdominal dressing and change daily. Review of the physician order for Resident #72 dated 07/24/25 at 10:44 A.M. by LPN #1027 revealed for the bilateral buttocks gluteal dermatosis, cleanse with soap and water, apply medical grade honey, xeroform, Zinc Oxide to the peri wound, change daily. Start date of 07/25/25. Review of the physician orders for Resident #72 dated 07/24/25 through 07/29/25 revealed no new treatment order for the left ischium unstageable pressure ulcer.Review of the TAR for Resident #72 dated 07/24/25 through 07/29/25 revealed the incorrect treatment order for the left ischium unstageable pressure ulcer and no treatment completed for the bilateral buttock gluteal dermatosis on 07/24/25 and 07/25/25.Review of the wound consult visit notes revealed Resident #72 was seen by WCNP #1055 on 07/30/25. The left ischium unstageable pressure ulcer worsened and measured 4.2 cm by 3 cm by 3.5 cm with undermining from 6 o'clock to 12 o'clock at 3.2 cm. Wound base 40 percent epithelial and 60 percent slough with continued exposed muscle/fascia and now a mild odor after cleansing. Required debridement. A new treatment plan of cleanse with wound cleanser/normal (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	saline, apply Santyl, Dakin's solution (no percent) moistened fluffed gauze to base of wound, secure with an abdominal dressing and change twice a day. The left heel has resolved. The bilateral buttocks gluteal dermatosis partial thickness worsened, measured 12 cm by 8 cm by 0.2 cm. Wound base 30 percent epithelial, 20 percent granulation, 50 percent slough and 20 percent eschar with mild odor after cleansing. Peri wound intact, erythema, fragile with moderate amount of serosanguinous exudate. A new treatment plan of cleanse with soap and water, apply medical grade honey, Calcium Alginate with Silver, Chamosyn to perilous to base of the wound, secure with abdominal dressing and change daily. A new facility acquired right ischium unstageable pressure ulcer measured 2.9 cm by 3.2 cm by 0.1 cm with wound base 20 percent epithelial and 80 percent eschar. Exposed tissues of the epithelium and dermis. A treatment plan of cleanse with soap and water, apply medical grade honey, Calcium Alginate with Silver to the base of the wound, secure with abdominal dressing and change daily. Review of the medical record for Resident #72 revealed no clarification/addendum with WCNP #1055 of the Dakin's Solution percent needed for the treatment of the left ischium unstageable pressure ulcer. Review of the physician order for Resident #72 dated 08/01/25 revealed a low air loss alternating pressure mattress to bed, check placement and function every shift. Review of the physician orders dated 08/01/25 at 12:38 A.M. by DON #2233 revealed no Dakin's Solution percent for the treatment of the left ischium unstageable pressure ulcer.Review of the physician orders for this resident dated 07/30/25 through 08/05/25 revealed no Dakin's Solution and Santyl ordered to come from the pharmacy. Review of the Medication Record Administration (MAR) and TAR dated 07/30/25 through 08/05/25 revealed the incorrect treatment completed for the left ischium unstageable pressure ulcer (due to no Santyl and Dakin's Solution). Review of the wound consult visit notes revealed Resident #72 was seen by WCNP #1055 on 08/06/25. The left ischium unstageable pressure ulcer measured 3.8 cm by 4.2 cm by 3.2 cm, undermining from 6 o'clock to 12 o'clock at 3.1 cm. Wound base 40 percent granulation and 60 percent slough with continued exposed muscle/fascia. Required debridement. A treatment plan to continue order from 07/30/25. The bilateral buttocks gluteal dermatosis full thickness measured 11.5 cm by 8.5 cm by 0.3 cm. Wound base 10 percent epithelial, 20 percent granulation, 50 percent slough, and 20 percent eschar. Peri wound intact, erythema, fragile with moderate amount of serosanguinous exudate. Required debridement. A new treatment plan of cleanse with wound cleanser, apply Santyl, Dakin's (no percent) solution moistened fluff gauze, nonstick contact layer to base of the wound, secure with abdominal dressing, change twice a day. The right ischium unstageable pressure ulcer measured 2.5 cm by 3 cm by 0.2 cm with the wound base 20 percent epithelial, 30 percent granulation, and 50 percent slough. Exposed tissues of the epithelium and dermis. Required debridement. A treatment plan to continue cleanse with soap and water, apply medical grade honey, Calcium Alginate with Silver to the base of the wound, secure with abdominal dressing and changed to twice a day. Review of the medical record for Resident #72 revealed no clarification/addendum with WCNP #1055 of the Dakin's Solution percent needed for the treatment of the left ischium unstageable pressure ulcer and bilateral buttocks gluteal dermatosis. Review of the physician order for Resident #72 dated 08/06/25 at 6:10 P.M. by LPN #1027 revealed (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	no Dakin's Solution percent for the treatment of the left ischium unstageable pressure ulcer and the frequency was daily. Review of the physician order for this resident dated 08/06/25 at 6:15 P.M. by LPN #1027 revealed a treatment for the bilateral buttocks gluteal dermatosis to cleanse with wound cleanser, apply Dakin's Solution (no percent specified) moistened gauze, Santyl nickel thick and cover with abdominal dressing every day, on day shift. Review of the physician orders for this resident dated 08/06/25 through 08/12/25 revealed no Dakin's Solution and Santyl ordered to come from the pharmacy. Review of the MAR and TAR dated 08/07/25 through 08/12/25 revealed the incorrect treatment completed for the left ischium unstageable pressure ulcer and the bilateral buttocks gluteal dermatosis (this was due to no Santyl, Dakin's Solution, and incorrect frequency.) Review of the wound consult visit notes revealed Resident #72 was seen by WCNP #1055 on 08/13/25. The left ischium unstageable pressure ulcer worsened, measured 4 cm by 4 cm by 3.3 cm, undermining from 6 o'clock to 12 o'clock at 3.1 cm. wound base 20 percent granulation, 80 percent slough, with continued exposed muscle/fascia and malodorous after cleansing. Required debridement. The treatment plan was to continue from 08/06/25. The bilateral buttocks worsened to an unstageable pressure ulcer, measured 13.5 cm by 10.2 cm by 1.5 cm. Wound base 10 percent granulation, 60 percent slough, 30 percent eschar with exposed tissue now including subcutaneous. Moderate amount of serosanguineous and purulent exudate with malodorous odor after cleansing. Required debridement. A treatment plan to continue from 08/06/25. The right ischium measured 4 cm by 5 cm by 0.4 cm with wound base of 20 percent epithelial, 30 percent granulation, and 50 percent slough. Exposed tissue now includes subcutaneous. Required debridement. The treatment plan changed to cleanse with wound cleanser, apply Dakin's Solution (no percent specified) moistened fluffed gauze, Santyl to base of wound, secure with an abdominal dressing and change twice a day. Review of the medical record for Resident #72 revealed no clarification/addendum with WCNP #1055 of the Dakin's Solution percentage needed for the treatment of the left ischium, right ischium and bilateral buttocks unstageable pressure ulcers. Review of the physician order for this resident dated 08/15/25 at 9:04 A.M. by LPN #1010 revealed Santyl, apply per additional directions topically every shift for wound care. Continued review of the physician orders for this resident dated 08/13/25 through 08/20/25 revealed no Dakin's Solution ordered to come from the pharmacy. Review of the MAR and TAR dated 08/13/25 through 08/19/25 revealed the incorrect treatment completed for the left ischium, right ischium, and bilateral buttocks, unstageable pressure ulcers due to no Santyl for 2 days no Dakin's Solution and incorrect frequency of the left ischium and buttocks treatment. There was no documentation of any concerns of Resident #72 refusing any pressure ulcer treatments/interventions. Review of the wound consult visit notes revealed Resident #72 was seen by WCNP #1055 on 08/20/25. The left ischium unstageable pressure ulcer measured 4 cm by 3.8 cm by 3 cm with no (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	documentation of assessment and description. Required debridement. A new treatment plan to cleanse with wound cleanser, apply medical grade honey, Collagen, and Calcium Alginate to wound bed, secure with abdominal dressing and change twice a day. The bilateral buttocks unstageable pressure ulcer measured 11 cm by 11 cm by 4.5 cm with no documentation of assessment and description. Required debridement. A treatment plan to continue from 08/06/25. The right ischium unstageable pressure ulcer had no documentation for measurements, assessments, descriptions and treatment plans. Review of the medical record for Resident #72 revealed no clarification/addendum with WCNP #1055 of the Dakin's Solution percent needed for the treatment of the bilateral buttocks unstageable pressure ulcer and for the right ischium pressure ulcer measurements, assessments, descriptions and treatment plan. Review of the physician orders for Resident #72 dated 08/20/25 through 08/27/25 revealed no Dakin's Solution ordered to come from the pharmacy. Review of the physician order for this resident dated 08/21/25 at 3:13 A.M. by LPN # 7777 revealed a CBC laboratory test for reported tarry stools. Review of the MAR and TAR dated 08/20/25 through 08/27/25 revealed the incorrect treatment completed for the right ischium, and bilateral buttocks unstageable pressure ulcers (no Dakin's Solution, and incorrect frequency of the buttocks treatment). Review of the complete blood count (CBC) laboratory results were received on 08/21/25 at 8:42 A.M. Resident #72's white blood cell (WBC) count was 14.9, which was high. Reported to facility on 08/21/25 at 12:58 P.M. Review of care visit for Resident #72 dated 08/21/25 by FNP #1052 revealed they were aware of WBC count of 14.9 with note of ongoing wound care for pressure ulcers. Review of the e-Care triage note for Resident #72 dated 08/24/25 at 12:23 P.M. by FNP #3333 revealed need to pain control for multiple pressure wounds as wounds are large and painful for dressing changes. Review of care visit for Resident #72 dated 08/25/25 by FNP #1052 revealed a follow up for pain of the sacrum pressure ulcer. Obtain another CBC laboratory test and obtain a sacrum (bilateral buttocks) wound culture. Review of the physician order for Resident #72 dated 08/25/25 at 4:01 P.M. by DON #2233 revealed a CBC laboratory test and a sacrum (bilateral buttocks) wound culture. Review of the CBC laboratory results for Resident #72 dated as received on 08/26/25 at 9:47 A.M. at 12:23 P.M. revealed a WBC count of 18.6, which was high. Reported to facility on 08/26/25 at 12:37 P.M. Review of the medical records for Resident #72 revealed no communication or notification of abnormal laboratory results reported to the FNP-BC #1052, Medical Director #1028 or the eCare triage center. Review of the progress note for Resident #72 dated 08/27/25 at 11:19 A.M. by LPN # 1010 revealed (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	labs reviewed with resident, resident requesting to go to emergency room and transported at 11:15 A.M. Review of the hospital admission documentation dated 08/27/25 for Resident #72 revealed admission for sacrum (bilateral buttocks) pressure ulcer osteomyelitis requiring intravenous antibiotics throughout stay. The resident was also assessed to have left and right ischium pressure ulcers. Review of the medical record from 09/01/25 through 01/30/26 revealed Resident #72 was totally dependent for bed mobility, at risk for pressure ulcers and continued to have a left ischium, right ischium and sacrum stage IV pressure ulcers. Review of the physician orders through that time period revealed delayed and incorrect treatment orders and plans of care and revealed interventions were not specific to Resident #72. Review the after-visit summary dated 01/31/26 for Resident #72 revealed wound care treatment for the sacrum and left ischium of cleanse with wound cleanser, apply Calcium Alginate, cover with dry gauze and secure with tape, change every other day and as needed. For the right ischium, apply Zinc Oxide daily and as needed. Follow up with Adena Wound Clinic for follow up care. Review of the progress note dated 01/31/26 at 6:28 P.M. for Resident #72 revealed returned to the facility from a hospital stay unrelated to the pressure ulcers. Review of the admission evaluation dated 01/31/26 at 10:30 P.M. for Resident #72 re-vealed the resident was alert and oriented to person, place and time, mobility to be very limited with the ability to change and control body position, a left buttock pressure ulcer area with no measurement and assessment and a Braden Scale for Predicting Pressure Sore Risk score of 14 indicated moderate risk on a scale of 6 (high risk) to 23 (no risk). Review of the physician orders for Resident #72 dated 01/31/26 and 02/01/26 revealed no treatments orders for the sacrum, left ischium and right ischium pressure ulcers. Review of the MAR/TAR dated 01/31/26 and 02/01/26 for Resident #72 revealed no treat-ments completed for the sacrum, left ischium and right ischium pressure ulcers. Review of the wound evaluation for Resident #72 dated 02/01/26 at 9:31 A.M. by LPN # 1077 revealed a left ischium stage IV pressure ulcer measured 2.5 cm by 3 cm by 1.5 cm. Review of the wound evaluation for this resident dated 02/01/26 at 9:38 A.M. by LPN #1077 revealed a right ischium stage IV pressure ulcer measured 0.5 cm by 0.7 cm by 0.2 cm. Review of the wound evaluation for this resident dated 02/01/26 at 9:46 A.M.

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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 observations, interviews, and review of facility policy, the facility failed to ensure foods were stored in a sanitary manner. This had the potential to affect all 74 residents residing in the facility who were identified as eating food prepared in the facility kitchen. The facility census was 74.Findings include:Observation on 02/09/26 at 6:34 P.M. revealed a large amount of flour was lying in the bottom of a plastic bin located on the second shelf inside the dry storage room. Three bags of open corn flakes were lying on a shelf and did not contain a date they had been opened. Soft taco shells were being stored inside plastic storage bags and were not labeled with a date opened. Interview with Dietary Employee #1201 at the time of the observation confirmed all opened foods were to labeled with the date opened and confirmed the plastic bin with flour in the bottom of it needed to be cleaned out. Observation inside the walk-in refrigerator on 02/09/26 revealed a large bag of shredded mozzarella cheese was lying on the shelf. The bag had been opened at the top corner and had not been closed or sealed after being opened. The bag was not labeled with the date opened and had a moderate amount of a light red substance located on the bag around the opening. A bag of salad mix had been opened and was not closed or sealed after being opened. Some of the lettuce inside the bag of the salad mix was light brown in color and was wilted and slimy in appearance. An open package of sliced hickory-smoked turkey breast was stored in a plastic storage bag and was dated as being opened on 12/29/25, 42 days prior. An open package of thick-sliced bologna was stored in a plastic storage bag and was dated as being opened on 12/25/25, 47 days prior. Two plastic storage bags containing boiled eggs with the shells removed and sliced ham which was yellow in color and contained a large amount of a slimy substance on the slices had not been labeled with dates opened or prepared. The bags of boiled eggs and sliced ham were lying in the bottom of a metal pan which an unknown red, thick liquid in the bottom of it. A plastic beverage pitcher was sitting on the top shelf and contained a brown, thick substance. The pitcher was not labeled with a date prepared or the substance inside it. A small plastic cup with a white plastic lid contained thin fluid which was white and clear. The plastic cup was not labeled with a date or the substance inside it. Interview with Dietary Employee #1205 at the time of the observation confirmed foods should be labeled with the date opened or prepared. Dietary Employee confirmed the package of thick-sliced bologna dated 12/25/25 and the package of sliced hickory-smoked turkey breast dated 12/29/25 were likely expired and should have been thrown out. Dietary Employee #1205 confirmed the plastic cup with the white and clear liquid appeared to be spoiled milk which had separated. Dietary Employee #1205 confirmed the metal pan with red, thick liquid in the bottom of it needed cleaned and food should not have been lying inside it. Dietary Employee #1205 confirmed food packages should be closed or sealed properly once opened to prevent spoiling of the food inside. Review of the facility policy titled Food Storage, dated 11/2025, revealed food will be stored in an area that is clean, dry, and free from contaminants. Food will be stored at appropriate temperatures and by methods designed to prevent contamination and cross-contamination. Food should be dated as it is placed on the shelves if required by state regulation. Leftover food should be stored in covered containers or wrapped carefully and securely and clearly labeled and dated before being refrigerated. Leftover food must be used within 7 days. All goods should be covered, labeled, and dated and routinely monitored to assure that foods (including leftovers) will be consumed by their safe use by dates, or frozen, or discarded. This deficiency represents non-compliance investigated under Complaint Number 2707280.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on record review, staff interview, and facility policy review, the facility failed to implement and maintain a comprehensive Quality Assurance Improvement Program (QAPI) program and plan to address care issues and/or concerns in the facility. This had the potential to affect all 74 residents who reside in the facility. The facility census was 74.Findings include:Review of the Quality Assurance (QA) committee attendance records for the previous eight months revealed QA meetings were held every month. Review of falls, pressure ulcers for residents that are healing, not healing, present on admission and or are in-house acquired, antibiotic use and weight loss are some of the areas discussed.The findings for the annual survey, dated 02/09/26 revealed noncompliance in the area of pressure ulcer care, which included prevention and treatments, resulting in substandard quality of care with an Immediate Jeopardy beginning on 08/27/25 for Resident #72 and an Actual Harm, beginning on 01/12/26 for Resident #6.Interview on 02/19/26 at 10:00 A.M. with the Administrator revealed the QAPI meetings are held monthly. He has attended the last two QAPI meetings since becoming the Administrator, which were December 2025 and January 2026 and will need to review the other six months of QAPI meetings that he was not in attendance. Verified at those two QAPI meetings, no residents were identified as ongoing issues and care for their pressure ulcers.Interview on 02/19/26 at 10:40 A.M. with the Administrator revealed no identification of ongoing issues and care for pressure ulcers at the facility for the previous six months of QAPI meetings prior to him (May 2025 through November 2025).Review of the facility policy titled Quality Assurance Performance Improvement dated November 2025 revealed Quality Assurance is a continuous process towards management where interventions are analyzed and targeted key performance improvement steps are identified. The Quality Assurance Committee has the overall responsibility and authority to conduct a confidential and privileged review of resident care and service trends to identify opportunities for performance improvement, identify quality issues and develop plans of action. Quality Assurance Performance Improvement is an ongoing process and reviews facility trends from data collection which includes quality of care with pressure ulcers.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and review of facility policy, the facility failed to ensure insulin and eye drops were labeled with the date opened and failed to ensure insulin glargine was discarded timely after being opened. This affected six residents (#9, #10, #24, #47, #55 and #60) whose medications were observed during the medication storage task. The facility census was 74.Findings include:Record review for Resident #9 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included senile degeneration of the brain, type two diabetes mellitus, and Alzheimer's disease. Review of the physicians order for Resident #9, dated 01/14/26, revealed 10 units of insulin glargine was to be administered subcutaneously at bedtime related to type two diabetes mellitus. Record review for Resident #10 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included chronic obstructive pulmonary disease, type two diabetes mellitus, and subluxation of the lens of the left eye. Review of the physicians order for Resident #10, dated 09/10/25, revealed one drop of 0.2 percent Brimonidine Tartrate Ophthalmic Solution was to be administered in the left eye three times a day related to subluxation of the lens of the left eye. Record review for Resident #24 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included metabolic encephalopathy, type two diabetes mellitus, and heart failure. Review of the physicians order for Resident #24, dated 02/14/26, revealed 20 units of insulin glargine was to be administered subcutaneously at bedtime for type two diabetes mellitus. Record review for Resident #47 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included chronic obstructive pulmonary disease, respiratory conditions due to smoke inhalation, and vascular dementia. Review of the physicians order for Resident #47, dated 11/25/25, revealed two puffs of Budesonide-Formoterol Fumarate Dihydrate 80-4.5 micrograms per actuation was to be inhaled by mouth twice a day for chronic obstructive pulmonary disease. Record review for Resident #55 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included acute kidney failure, bipolar disorder, and primary open-angle glaucoma. Review of the physicians order for Resident #55, dated 05/20/25, revealed one drop of 0.005 percent Latanoprost Ophthalmic Solution was to be administered in each eye at bedtime related to primary open-angle glaucoma. Record review for Resident #60 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included type two diabetes mellitus, cerebral infarction, and vascular dementia. Review of the physicians order for Resident #60, dated 12/08/24, revealed 40 units of Lantus was to be administered subcutaneously at bedtime for diabetes mellitus. Observation of the C-Hall medication cart on 02/19/26 at 8:38 A.M. with Licensed Practical Nurse (LPN) #1037 revealed Resident #24's insulin glargine was open and was not labeled with the date it had been opened, Resident #55's Latanoprost eye drops were open and were not labeled with the date opened, and Resident #10's Brimonidine eye drops were open and were not labeled with the date opened. Interview with LPN #1037 at the time of the observation confirmed resident eye drops and insulin were to be labeled with the date when opened by the nurse. Observation of the B-Hall medication cart on 02/19/26 at 8:46 A.M. with LPN #1094 revealed a vial of insulin glargine had been pulled from the emergency drug box and was placed in the medication cart for Resident #60 but was not labeled with the date the bottle was opened. The Budesonide-Formoterol Fumarate Dihydrate inhaler for Resident #47 was open and was not labeled with the date opened. Insulin glargine for Resident #9 was in the medication cart and was dated as being opened on 01/16/26, 34 days prior. Interview with LPN #1094 at the time of the observation confirmed residents insulin and inhalers were to be labeled with date when opened by the nurse. LPN #1094 confirmed Resident #9's insulin glargine was dated as being opened on 01/16/26, 34 days prior to the observation. Review of the facility policy titled Storage of (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medications, dated 11/2025, revealed the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. Insulin glargine expires 28 days after first use or removal from the refrigerator, whichever comes first.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record reviews, review of hospital discharge records, interviews, and review of facility policy, the facility failed to ensure advance directives were ordered and implemented timely upon admission or readmission to the facility. This affected two residents (#72 and #92) out of the two residents reviewed for advance directives. The facility census was 74.Findings include:1. Record review for Resident #92 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included hypertensive emergency, acute pulmonary edema, and Sjorgen syndrome. Review of the hospital Discharge summary, dated [DATE], revealed the resident code status was Do Not Resuscitate - Comfort Care Arrest (DNRCCA). Review of the physician orders for Resident #92 revealed an order for advance directives had not been initiated until 02/10/26 and listed the resident as Full Code status. Review of the DNRCCA paperwork, signed by the physician on 02/05/26, revealed the paperwork was uploaded into the resident's electronic health record on 02/11/26. Interview with Regional Director of Clinical Services (RCDS) #1050 on 02/10/26 at 2:30 P.M. confirmed Resident #92 was admitted to the facility on [DATE] and physician orders for code status were not implemented until 02/10/26. RCDS #1050 confirmed the hospital discharge summary listed the resident as being DNRCCA code status but the facility had not obtained signed DNR paperwork so the resident had to be Full Code status until the paperwork was obtained. Interview with [NAME] President of Clinical Services (VPCS) #1029 on 02/12/26 at 11:18 A.M. confirmed the signed DNRCCA paperwork for Resident #92 had been signed by the physician on 02/05/26 and uploaded into the residents electronic health record on 02/11/26. VPCS #1029 confirmed the physicians order for code status for Resident #92 remained Full Code status on 02/12/26 but would be updated. Review of the facility policy titled Advance Directives Guidance, dated 01/2026, revealed upon admission a nurse will question the resident about advance directives. All residents without advance directives will be treated as a full code. The Ohio Advance Directive form will need to be fully executed by the resident physician or physician extender: next a nurse will obtain a physician order following the advanced directive wishes of the resident. The advanced directive order will be entered into the resident's electronic health record. 2. Review of the medical record for Resident #72, revealed an admission date of 07/03/25. Diagnoses included but were not limited to left buttock stage 4 pressure ulcer, paraplegia, generalized anxiety disorder, major depressive disorder, neuromuscular dysfunction of bladder. Review of the DNRCCA paperwork for Resident #72, signed by the physician on 01/27/26, revealed the paperwork was uploaded into the resident's electronic medical record on 01/06/26. Review of the physician orders for Resident #72 dated 01/31/26 through 02/10/26 revealed no order for their code status entered into the electronic medical record. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/10/26 at 2:35 P.M. with director of nursing (DON) #1057 confirmed upon readmission from a hospital stay on 01/31/26, a DNRCCA physician order was not placed in the electronic medical record, and it will be added. Review of the facility policy titled Advance Directives Guidance, dated 01/2026, revealed The Ohio Advance Directive form will need to be fully executed by the resident physician or physician extender: next a nurse will obtain a physician order following the advanced directive wishes of the resident. The advanced directive order will be entered into the resident's electronic health record.

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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 record review, policy review, and staff interview, the facility failed to provide and document sufficient preparation to ensure a safe and orderly transfer or discharge from the facility and ensure the discharge planning process addressed each residents discharge goals and needs. This affected two residents (#4, #32) of three residents reviewed for transfer or discharge from the facility. The facility census was 74.Findings include: 1. Review of the record for Resident #32 revealed an admission date of 01/13/26 and diagnoses including alcohol dependence in remission, chronic obstructive pulmonary disease, and rheumatoid arthritis. Review of a Minimum Data Set assessment completed 01/19/26 revealed a brief interview for mental status (BIMS) score of 14 (intact cognition). Review of nursing and physician progress notes from admission through 02/12/26 did not reveal any issues related to alcohol consumption. The plan of care dated 01/19/26 and revised 02/11/26 stated he had a history of substance abuse (alcohol and drugs). It further stated he will purchase alcohol and drink at the facility. Interventions included to monitor and report signs of misuse to the physician, and nurses to notify physician if resident consumes too much alcohol and there is a concern due to medications. A social service evaluation on 01/13/26 stated the resident was admitted for skilled services. Resident stated he would be discharging home to his daughters. Resident expressed he has been going from family to family since 2024. Stated he would like to get his own place at some time. Receives social security income. He expressed that he had lived in his jeep as well. Is alert and oriented. No concerns with mood or behaviors at this time. Further review of Resident #32's care plan dated 01/19/26 revealed the resident planned to discharge to community with his daughter. The goal was for him to have a safe transition back to the community. Interventions included encourage resident/family to participate in the discharge planning process, involve specialized home care agencies and appropriate community support services as needed for safe discharge, provide resident/family with written instructions upon discharge to ensure a safe return to the community. Review of nursing progress notes on 02/13/26 at 2:30 P.M. by Licensed Practical Nurse (LPN) #1010 revealed this nurse was notified by another staff member that Resident #32 had fallen in the hallway and hit his head on the medication cart. It stated the resident was under the influence of alcohol. It stated he had an abrasion to the left eyebrow. The note stated the nurse practitioner, resident representative, administrator and unit managers were notified. On 02/13/26 at 2:31 P.M. LPN #1010 documented the resident was alert and oriented x 4 and was refusing to go to the hospital for further evaluation. Resident admitting he had 1 beer today. Resident educated on the risk of bleeding and injury due to fall. Resident continued to refuse. Neuro check initiated. The next entry in the nursing progress notes by LPN #1010 on 02/13/26 at 4:27 P.M. (approximately 2 hours after the fall) revealed report was called to another nursing facility to notify the facility that the resident was being transported there. All medications being sent with resident to the facility. On 02/13/26 at 4:59 P.M. LPN #1010 documented an entry correction due to misunderstanding of the recall of events of the fall. This nurse was notified by another staff member that resident stated he fell outside on the sidewalk and hit his head and was witnessed by other residents, then had fallen into the medication cart and was caught by staff. A late entry in the nursing progress notes on 02/13/26 at 5:55 P.M. by [NAME] President of Clinical Services #1029 revealed Resident #32 was transferred to another nursing facility per his request. (Even though the resident was noted to be intoxicated at the time). Review of a discharge plan of care dated 02/13/26 stated Resident #32 was discharged to another nursing home. It stated a medication list was faxed to the new facility. The discharge plan provided no further documentation regarding how it came to be that he was transferred to another nursing facility. The following notes were entered into Resident #32's record by the facility he was transferred to: On 02/13/26 at 11:59 P.M. the nurse practitioner had entered triage notes that included details after the resident was transferred (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the new facility. It included notes from 5:49 P.M. that stated new admit from sister facility. Do you still want meds to be held until tomorrow due to alcohol consumption. It stated the resident was agitated and exit seeking. Amount of alcohol consumed is unknown. The note also stated this resident has been consuming alcohol daily at the other facility. Is there specific precautions we need to or should put in place for him given he will have limited or no access to alcohol at our facility. Uncertain of how much he has been consuming daily. He also had a fall at the other facility prior to coming to ours. Details are limited related to the fall. The note then stated that at 9:02 P.M. he is now complaining of double vision. He has an abrasion above his left eyebrow. The details of the fall are unknown. He is requesting to go the emergency room. He states he is nauseated. The area above his left eyebrow is prominent. The note stated to send him to the emergency room. Interview with LPN #1010 on 02/17/26 at 11:20 A.M. revealed she was Resident #32's nurse on 02/13/26. She confirmed he fell around 2:30 P.M. She stated he had been outside smoking and other resident's saw him fall. She stated staff then saw him stumbling in the hall and he hit the medication cart and staff caught him. She stated he reeked of alcohol and appeared intoxicated. She stated he refused to go to the hospital for evaluation. She stated the Administrator then talked to the resident about his drinking, the fact that he had fallen, and where he preferred to go. She stated the resident still smelled of alcohol. She stated she did not know how the facility he was transferred to was decided upon as the place to send him. She stated he was then transported by the facility bus to the other nursing facility around 5:55 P.M. She stated he had never had exit seeking behavior at this facility as he was able to come and go as he wanted. She stated she did not know why the facility he was transferred to would be documenting that. She stated it could be because she thought the new facility was not close to any gas stations and he always walked there to get snacks, lottery tickets, and alcohol. Interview with the Administrator on 02/18/26 at 10:20 A.M. revealed the other nursing facility had just happened to call on 02/13/26 and asked the facility if they had any residents with behavior issues that would be better suited at their facility. He stated he was aware Resident #32 had fallen on 02/13/26 prior to his transfer but was not aware he had been drinking alcohol. He stated there had been one prior incident of the resident bringing alcohol into the facility and they had discussed about not being able to give him his medications if he was drinking. He stated he did not know if the transfer to the other facility had been discussed with the physician. He stated that the resident had stated that he preferred to move closer to another city (not where he was transferred) but the facility had not had the staffing to handle trying to find somewhere for him to move where he wanted. There was no further documentation in the record regarding the reason for the transfer to another nursing home or why the resident's previous discharge plan of discharging to family home was no longer his plan. There was no documentation to indicate how the new nursing facility was chosen or how it could meet the needs of the resident differently than the present facility. Review of the Alcohol use policy dated January 2026 revealed the facility recognizes the rights of residents to make personal choices regarding their lifestyle, including the consumption of alcoholic beverages, provided the consumption does not adversely affect the resident's health, safety, care plan, other residents, or facility operations. Alcohol consumption will be permitted in accordance with this policy. During the course of the investigation, multiple attempts to interview Resident #32 were unsuccessful. 2. Review of the closed medical record for Resident #4 revealed an admission date of 01/16/26 with diagnoses including respiratory failure, alcoholic cirrhosis of the liver, diabetes, alcohol abuse, viral hepatitis, post traumatic stress disorder, and bipolar disorder. A Minimum Data Set assessment completed 01/22/26 documented a BIMS score of 15 (intact cognition). Review of a physician progress note on 01/19/26 revealed Resident #4 was admitted after a hospital stay for alcohol detoxification and hypoxia. She reports heavy alcohol consumption since Christmas, escalating from a pint daily to approximately 1.5 fifths daily. Has a history of alcohol withdrawal seizures and completed alcohol withdrawal treatment during this admission. admitted here for rehab. Wishes to return to VA when a bed comes available. Lives with husband. Review of social service note by Business Office Manager #1059 on 01/30/26 at (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3:44 P.M. revealed the resident was accepted for inpatient rehab program at the VA tentatively scheduled for transfer to VA on 02/05/26. The next nursing progress note on 01/31/26 at 8:09 A.M. stated the resident came to the facility, picked up her belongings and her ordered medications. Educated resident on her discharge and follow up visit at VA. There was no further documentation regarding the reason for the discharge. Interview with Business Office Manager #1059 on 02/18/26 at 9:44 A.M. revealed she was helping with social services at the time of Resident #4's discharge. She stated the resident had authorization from the VA to stay at the facility for 30 days. She was then to be transferred to the VA on 02/05/26 to an inpatient alcohol rehab program. She stated the resident did go out of the facility daily after she received her therapy for the day. She stated when she (Business Office Manager #1059) left for the day on 01/31/26 the plan was for the resident to stay at the facility until the transfer to the VA on 02/05/26. She stated the discharge was done in the evening by the nurse and she was not informed prior to the resident discharging home. She stated a discharge would require a physician's order. If there was not a physician's order to discharge, then it would be against medical advice. She stated this discharge was not handled as an against medical advice discharge. Interview with Resident #4 by telephone on 02/18/26 at 9:07 A.M. revealed she left the faciity on [DATE] and went home. She stated she was then admitted to the VA on 02/05/26 and remained at the VA at this time. When asked why she went home on [DATE] instead of staying at the facility until 02/05/26 as planned, she stated that someone at the facility talked to her about her leaving the facility everyday to go home after therapy. She stated that after that conversation, she decided to discharge home. Interview with the Director of Nursing on 2/18/26 at 10:31 A.M. confirmed there was not a physician's order to discharge the resident and there was no evidence the physician was aware of the discharge home. She stated if the physician did not agree to the discharge home, then the discharge should have been done as against medical advice, and was not. Review of a discharge plan of care dated 01/31/26 revealed Resident #4 was discharged home. There was no evidence the physician was aware of the discharge and there was no physician's order to discharge. There was no further documentation to indicate why the resident was discharged home instead of transferring to the VA on 02/05/26 as planned. Review of the facility policy date November 2025 titled Discharge Summary and Plan revealed when a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment. Every resident will be evaluated for his or her discharge needs. The post discharge plan will be developed by the interdisciplinary team with the assistance of the resident and his or her family. Residents will be asked about their interest in returning to the community. If the resident indicates an interest, he or she will be referred to local agencies and support services that can assist in accommodating the resident's post-discharge preferences. Residents transferring to another skilled nursing facility will be assisted in selecting a provider that is relevant and applicable to the residents goals of care and treatment preferences.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review and staff interview, the facility failed to ensure Level II Preadmission Screening and Resident Review (PASARR) recommendations were implemented timely and appropriately. This affected the one resident (#10) of one resident who was reviewed for PASARR recommendations. The facility census was 74.Findings include:Record review for Resident #10 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included acute respiratory failure with hypoxia, bipolar disorder, schizoaffective disorder, personality disorder, anxiety disorder, obsessive compulsive disorder, post-traumatic stress disorder, and attention deficit hyperactivity disorder. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/01/25, revealed the resident was assessed to have mildly impaired cognition. Review of the Notice of PASRR Level II Outcome, dated 08/25/25, revealed recommendations for 1:1 staffing due to a history of head banging and fire starting, self-injurious items should be placed out of reach to prevent injury, group therapy with a trained group therapist, a behavior management safety plan to decrease inappropriate behaviors and ensure safety, and ongoing evaluation of the effectiveness of current psychotropic medications on target symptoms. Interview with Business Office Manager (BOM) #1059 on 02/12/26 at 9:29 A.M. confirmed the employee was in the position of Social Service Director at the time of the Level II PASARR recommendations for Resident #10. BOM #1069 confirmed the Level II PASARR recommendations for 1:1 staffing due to a history of head banging and fire starting, self-injurious items should be placed out of reach to prevent injury, group therapy with a trained group therapist, a behavior management safety plan to decrease inappropriate behaviors and ensure safety, and ongoing evaluation of the effectiveness of current psychotropic medications on target symptoms had not been addressed or implemented as recommended. BOM #1059 confirmed Resident #10 had not exhibited any head banging, self-injurious behavior, or fire starting since admission to the facility.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews and facility policy review, the facility failed to document non pressure areas upon admission and initiate treatments for Residents #6, #22, #34. The facility also failed to ensure new and/or ongoing non pressure areas treatments were accurate. This affected Resident #2 and Resident #6. This affected four residents (#2, #6, #22, and #34) of the six residents reviewed for non-pressure skin alterations. The facility census was 74.Findings include:1. Review of the medical record for Resident #2, revealed an admission date of 02/07/26 Diagnoses included but were not limited to other reduced mobility, need for assistance with personal care, muscle weakness and unspecified severe protein calorie malnutrition . Review of the most recent Minimum Data Set (MDS) 3.0 assessment revealed in progress at the time of this survey. Review of the plan of care dated 02/10/26 for Resident #2 revealed at risk for impaired skin integrity related to poor nutritional intake and confined to bed all or most of the time with an intervention including but not limited to encourage/assist as needed to elevate heels off mattress as tolerated and treatments per physician/CNP orders. Review of the admission assessment for Resident #2 dated 02/07/26 at 2:25 P.M. revealed alert and oriented to person, place and time, 1-person assistance for transfers, and bed mobility with skin impairments that included left heel open area with black scabbing surrounding. Review of the wound evaluation dated 02/07/26 for Resident #2 revealed a left heel open wound measured 2.6 cm by 1.8 cm by 0.4 cm. Review of the physician order dated 02/08/26 revealed a treatment for the left heel open wound of cleanse with wound cleanser, apply medihoney, cover with apply nonstick dressing, wrap with kerlix and ace wrap daily. Review of the wound consult visit notes revealed Resident #2 was seen by Wound Consultant Nurse Practitioner (WCNP) #1054 on 02/10/26. The left heel is a diabetic foot ulcer measured 0.5 cm by 0.5 cm by 0.3 cm. A treatment plan to cleanse with wound cleanser, apply medical grade honey to the base of the wound, secure with abdominal dressing, rolled gauze and change daily. recommendations to float heels while in bed. Review of the physician orders for Resident #2 dated 02/10/26 through 2/17/26 revealed treatment order for the left heel was continued from 02/08/26. Review of the Treatment Administration Record (TAR) for Resident #2 dated 02/10/26 through 02/17/26 revealed the incorrect treatment completed for the left heel. Observation and interview on 02/11/26 at 7:38 A.M. with Resident #2 revealed him in bed with heels not elevated. Interview and observation on 02/17/26 at 10:30 A.M with CNA #1095 confirmed Resident #2 in bed with heels not elevated off bed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/18/26 at 2:14 P.M. with RDCS #1050 verified treatment order for the left heel was not ordered per the WCNP #1054 on 02/10/26 and resident received the wrong treatment for 02/10/26 through 02/17/26. 2 Review of the medical record for Resident #6, revealed an admission date of 01/03/26. Diagnoses included but were not limited to type 2 diabetes mellitus with diabetic neuropathy, moderate protein-calorie malnutrition, chronic kidney disease stage 3 and personal history of other diseases of the circulatory system. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of moderate cognitive impairment. The resident was assessed to require substantial/maximal assistance with shower/bathe self, bed mobility, and total dependence with toilet hygiene and transfers. Review of the Adena hospital stay from admission on [DATE] through discharge to the facility on [DATE] for Resident #6 revealed vascular wounds of the left lower anterior and distal leg, unclear etiology wound of the left calf and unclear etiology wounds to the right calf. Treatment to cleanse wounds to BLEs with wound cleanser and pat dry. Apply double layer of Xeroform to wound beds, cover with 4x4 gauze, then wrap with Kerlix and ACE wraps, from base of toes to Tibial Tuberosity with both. Change every other day and as needed if dressing becomes soiled. Review of the admission assessment for Resident #6 dated 01/03/26 at 5:00 P.M. revealed alert and oriented to person and place and a skin impairment of a skin tear observed. Review of the plan of care initiated on 01/06/26 for Resident #6 revealed impaired skin integrity with interventions including but not limited to complete wound evaluation to monitor the progress of the resident's skin condition and treatments per physician/CNP orders. Review of the physician order dated 01/05/26 with a start date of 01/06/26 for Resident #6 revealed a treatment order for the bilateral lower extremities, cleanse with wound cleanser and pat dry. Apply double layer of Xeroform to wound beds, cover with 4x4 gauze, then wrap with Kerlix and ACE wraps, from base of toes to Tibial Tuberosity with both. Change every other day and as needed if dressing becomes soiled. Review of the TAR for Resident #6 dated 01/03/26 through 01/05/26 revealed no treatment completed for the bilateral lower extremities wounds. Review of the medical record for Resident #6 dated 01/03/26 through 01/11/26 revealed no assessments and measurements of the skin tear and the bilateral lower extremities. Review of the wound consult visit notes revealed Resident #6 was seen by WCNP #1055 on 01/12/26. The left shin venous ulcer assessed and a treatment plan of cleanse with wound cleanser, apply Collagen, Xeroform to base of the wound, secure with abdominal dressing, kerlix, ace wrap and change daily. The right elbow skin tear was assessed and a treatment plan of cleanse with wound cleanser, apply Collagen Hydrogel, nonstick contact layer to base of the wound, secure with bordered foam and change every other day. Review of the physician order dated 01/14/26 to start on 01/15/26 for Resident #6 revealed a treatment order for the left shin venous ulcer of wash with wound cleanser, apply Collagen, Xeroform (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to base of the wound, secure with abdominal dressing, kerlix, ace wrap and change daily. Further review of the physician order for this resident dated 01/14/26 to start on 01/15/26 revealed a treatment order for the right elbow skin tear to was with wound cleanser, apply Collagen Hydrogel, nonstick contact layer to base of the wound, secure with bordered foam and change every other day. Review of the TAR for Resident #6 dated 01/12/26 through 01/15/26 revealed no treatment completed for the left skin venous ulcer. Further review of the TAR for this resident dated 01/12/26 through 01/18/26 revealed no treatment completed for the right elbow skin tear. Review of the wound consult visit notes revealed Resident #6 was seen by WCNP #1055 on 01/19/26. The left shin venous ulcer assessed and continue treatment as 01/12/26 and the right elbow skin tear healed out. Review of the wound consult visit notes revealed Resident #6 was seen by WCNP #1055 on 01/27/26. The left shin venous ulcer healed out. A new area of a right shin skin tear assessed and a treatment plan of cleanse with wound cleanser, apply Collagen, xeroform, nonstick contact layer to base of the wound, secure with an abdominal dressing, kerlix and change daily. Review of the physician order dated 01/27/26 for Resident #6 revealed cleanse with wound cleanser, apply Collagen, xeroform, nonstick contact layer to base of the wound, secure with an abdominal dressing, kerlix and change daily. no site indicated. Review of the TAR dated 01/27/26 through 01/29/26 for Resident #6 revealed no treatment for the right shin skin tear completed. Review of the physician order dated 01/30/26 for Resident #6 revealed for the right shin a treatment of cleanse with wound cleanser, apply Collagen, xeroform, nonstick contact layer to base of the wound, secure with an abdominal dressing, kerlix and change daily. Review of the wound consult visit notes revealed Resident #6 was seen by WCNP #1054 on 02/10/26. The right shin skin tear was assessed and continue treatment from 01/27/26. Interview on 02/18/26 at 2:16 P.M. with the RDCS #1050 verified for Resident #6 from admission to 01/30/26, no assessments and measurements for areas identified on admission until 1/12/26 with order and admission skin assessment and treatment orders not followed as ordered and/or not initiated timely resulting in not documented treatments for non-pressure wounds during that time frame. 3.Review of the medical record for Resident #22, revealed an admission date of 01/13/2026. Diagnoses included but were not limited to cellulitis of the left lower limb, Type 2 diabetes with diabetic neuropathy, hypertensive heart disease without heart failure, chronic kidney disease Stage 3, non-pressure chronic ulcer of other part of left foot limited to breakdown of skin, venous insufficiency and polyneuropathies. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #22 revealed a Brief Interview for Mental Status (BIMS) of 15. The resident was assessed to require (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	setup/cleanup assistance with toileting and personal hygiene, supervision with shower/bathing, and independent with sitting to lying/lying to sitting/sitting to stand and transferring. Review of the plan of care dated 01/25/2026 for Resident #22 revealed impaired metabolic status related to diabetes mellitus with interventions including but not limited to medications and treatments as indicated. Further review of the plan of care for this resident revealed impaired skin as evidenced by the right lateral plantar diabetic foot ulcer and left lateral plantar diabetic foot ulcer with an intervention including but not limited to complete wound evaluation to monitor the progress of the resident's skin condition. Review of the hospital Discharge summary dated [DATE] for Resident #22 revealed an order to cleanse bilateral lower extremities diabetic ulcers with 0.9 normal saline, pat dry, apply xeroform to all wound after applying Adaptec Calcium Alginate to the left plantar 5th metatarsal. Cover all with dry gauze, ABD, Kerlix, and Ace bandage daily. Review of the admission assessment dated [DATE] for Resident #22 revealed no skin impairments noted with reason for admission being cellulitis to the left foot. Review of the physician orders dated 01/13/26 through 01/16/26 for Resident #22 revealed no treatment orders for the bilateral lower extremities diabetic foot ulcer wounds. Review of the TAR for Resident #22 dated 01/13/26 through 01/16/26 revealed no treatments completed for the bilateral lower extremities diabetic foot ulcers. Review of the medical record for Resident #22 from 01/14/26 through 01/19/26 revealed no measurements and assessments of the left lateral plantar diabetic foot ulcer and right lateral plantar diabetic foot ulcer. Review of the progress note dated 01/17/2026 for Resident #22 revealed a telephone order for daily treatments for the bilateral lower diabetic foot ulcers and to contact outside wound care on Monday 1/19/26 by Nurse Practitioner (NP) #1052. Review of the physician orders dated 01/17/26 for Resident #22 revealed wound cleanser to bilateral lower extremity diabetic foot ulcers, pat dry, apply Xeroform to open areas and wrap with kerlix – daily and as needed. Review of the wound overview dated 01/20/26 for Resident #22 revealed the left lateral plantar diabetic foot ulcer was 1.5 cm by 1.7 cm by no depth and a right lateral plantar diabetic foot ulcer was 1.5 cm by 1.7 cm by no depth. Interview on 02/17/26 at 10:00 A.M. and 02/18/26 at 9:27 A.M. with the DON revealed no additional information regarding Resident #22's bilateral diabetic foot ulcers in regards to no wound assessment completed from admission until 01/20/26 as well as orders not being initiated upon admission for treatments until 01/17/26. 4.Review of the medical record for Resident #34, revealed an admission date of 01/02/26. Diagnoses included but were not limited to acute hematogenous osteomyelitis, acquired absence of the left leg (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	below the knee, Type 2 diabetes, COPD, chronic kidney disease, peripheral vascular disease, MI, and hypertensive heart disease without heart failure. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #34 revealed a Brief Interview for Mental Status (BIMS) of 14. The resident was assessed to require setup/cleanup assistance with eating, moderate assistance with oral hygiene, and personal hygiene, maximal assistance with shower/bathing, dressing, rolling and sitting dependent on toileting, lying to sitting, sitting to stand and transfers. Review of the plan of care dated 01/04/2026 for Resident #34 revealed the resident with impaired metabolic status related to diabetes mellitus with an intervention including but not limited to treatments as indicated by physician orders. Further review of the plan of care for this resident revealed impaired skin integrity as evidenced by a right lateral 5th toe diabetic foot ulcer and left below knee amputation closed surgical wound with an intervention including but not limited to complete wound evaluation to monitor the progress of the resident's skin condition. Review of the medical record for Resident #34 revealed upon transfer to the hospital, the resident had skin impairments of a left below knee amputation surgical wound and right lateral 5th toe diabetic ulcer. Review of medical record for Resident #34 revealed a hospital stay unrelated to the non-pressure wounds from 01/19/26 through 01/23/26. Review of the hospital discharge instructions dated 01/24/26 revealed no non pressure wound care treatment orders. Review of the readmission assessment dated [DATE] on Resident #34 revealed a vascular skin impairment and surgical incision noted. No locations, assessments and measurements completed. Review of the physician orders dated 01/23/26 through 01/27/26 revealed no treatment orders for the left below knee amputation surgical wound and right lateral 5th toe diabetic ulcer. Review of the TAR for Resident #34 dated 01/23/26 through 01/27/26 revealed no treatments completed for the left below knee amputation surgical wound and right lateral 5th toe diabetic ulcer. Review of the medical record for Resident #34 from 01/23/26 through 01/27/26 revealed no assessments and measurements of the left below knee amputation surgical wound or right lateral 5th toe diabetic ulcer. Review of orders for 01/28/26 for Resident #34 revealed an order for the right lateral 5th toe diabetic foot ulcer stating to wash with wound cleanser, pat dry, apply skin prep and leave open to air twice a day. For the left below knee amputation surgical incision on Resident #34 dated 01/28/26 order to cleanse area with wound cleanser, pat dry, and apply sterile dressing daily. Review of the wound overview dated 01/27/26 for Resident #34 revealed a left below knee amputation surgical wound measuring 0.2 cm by 25.0 cm by 0.1 cm and a right lateral 5th toe diabetic ulcer measuring 0.8 cm by 0.4 cm by no depth. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/17/26 at 10:00 A.M. and 02/18/26 at 9:27 A.M. with the DON revealed no additional information regarding Resident #34's left below knee amputation surgical wound and right lateral 5th toe diabetic ulcer in regards to no wound assessments completed from admission until 01/27/26 as well as no orders being initiated upon re admission until 01/27/26.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, policy review, and staff interview, the facility failed to ensure the smoking policy was implemented to ensure the environment was free from hazards, and failed to implement assistive devices to prevent falls. This affected two residents (#39, #41) of three residents reviewed for accidents. The facility census was 74. Findings include: 1. The facility identified 15 residents as smokers, including Resident #39. Nine of the residents were identified as independent with smoking and six were identified as supervised with smoking. Resident #39 was identified as an independent smoker. Review of the record for Resident #39 revealed an admission date of 08/19/25 and diagnoses including cerebral vascular accident with hemiplegia and hemiparesis, diabetes, and hypertension. A Minimum Data Set assessment completed 01/19/26 documented a brief interview for mental status score of 15 (intact cognition). A smoking evaluation conducted 11/26/25 and 02/10/26 stated the resident may smoke independently. Review of the plan of care for Resident #39 dated 6/6/25 revealed the resident is a smoker. The goal was for the resident to follow the facility rules for designated smoking areas and smoking materials. An intervention included informing the resident of the storage of smoking materials. Observations on 02/10/26 at 3:20 P.M. revealed Resident #39 to have his cigarettes and lighter stored in his coat pocket in his room. Resident #39 stated it was permissible for him to store the items in his room. Review of the facility undated smoking policy revealed residents will smoke in designated areas only. Resident smoking materials will be retained and distributed by the facility staff to the residents during designated smoking times and/or when independent residents choose to smoke. Interview with the Administrator on 02/10/26 at 3:30 P.M. revealed residents are not to keep cigarettes and lighters in their rooms. He stated independent smokers are to lock their cigarettes and lighter in a box by the exit door to the smoking area after they are done smoking. The cigarettes and lighter are to be stored in the locked box until they smoke again. Interview with the Administrator on 02/12/26 at 8:48 A.M. revealed the social worker did verify that Resident #39 had his cigarettes and lighter in his room after the surveyor notified the Administrator on 02/10/26. He further confirmed that the facility smoking policy did not address that independent smokers were keeping their cigarettes in a locked box by the exit door. He stated independent smokers have keys and started using the locked boxes around October 2025. 2.Review of the medical record for Resident #41 revealed an admit to the facility date of 10/07/25 with diagnoses including but not limited to dementia, chronic obstructive pulmonary disease, schizoaffective disorder, polyneuropathy, and muscle weakness. Review of the Medicare Quarterly Minimum Data Set (MDS) 3.0 assessment, dated 10/13/25 for Resident #41, revealed a Brief Interview for Mental Status (BIMS) of 15. This resident required (continued on next page)

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	365694	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hopewell Grove Rehabilitation and Healthcare	60 Marietta Road Chillicothe, OH 45601

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supervision or touching assistance with toileting, lying to sitting, sitting to lying, sitting to stand and rolling with partial assistance with bathing/showering. This resident was also assessed to have had one fall since admission with no injury. Review of the plan of care dated 10/08/25 for Resident #41 revealed at risk for falls related to generalized weakness with interventions in place. Review of progress note dated 11/30/25 at 12:40 A.M. for Resident #41 revealed the resident had fallen asleep while sitting, then lying on the side of the bed and ended up sliding off the bed. No injuries were noted. Review of the plan of care revised on 11/30/25 revealed at risk for falls related to generalized weakness and intervention including but not limited to educate and encourage resident to position themselves in the middle of the bed upon lying down. Review of progress notes dated 12/01/25 for Resident #41 revealed a follow up occurrence note with fall intervention of resident being educated and encouraged to position themselves in the middle of the bed upon lying down. Review of fall risk assessment dated [DATE] for Resident #41 revealed a score of 65 indicated at high risk. Review of progress note dated 01/03/26 at 12:30 A.M. for Resident #41 revealed resident was found lying on the floor next to bed after sliding off the edge while sleeping. No injuries were noted. Review of plan of care revised on 01/03/26 for Resident #41 revealed at risk for falls related to generalized weakness with an added intervention of a perimeter mattress. Review of progress notes dated 01/04/26 and 01/06/26 for Resident #41 revealed a follow up occurrence noted with intervention noted for perimeter mattress added to bed. Review of the plan of care revised on 02/10/26 for Resident #41 revealed at risk for falls related to generalized weakness with the intervention of a perimeter mattress resolved with no added intervention in its place. Review of Restraint Enabler Decision Tree dated 02/11/26 for Resident #41 revealed assist rails bilaterally to bed to promote participation in mobility and repositioning. Review of the medical record for Resident #41 from 01/04/26 through 02/10/26 revealed no falls while in bed. Review of the Therapy Screening form dated 02/09/26 for Resident #41 completed by Physical Therapy Assistant (PTA) #1026 revealed an evaluation for grab bars in place of a perimeter mattress as this resident was in occupational therapy for upper extremity strengthening. No documentation on assessment of her bed mobility with a perimeter mattress noted. Interview and observation with the Director of Nursing (DON) on 02/12/26 at 8:19 A.M. revealed no perimeter mattress for Resident #41, but that it had been resolved due to physical therapy recommending handrails as a better alternative to prevent falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #41 on 02/12/26 at 8:41 A.M. revealed no recollection of whether the mattress had been changed. Stated there was no discussion or education on bed rails being added to the bed and they were just there one day. Interview on 02/12/26 at 8:49 A.M. with the DON revealed for Resident #41, it was discussed with physical therapy in their morning meeting, that the perimeter mattress might be affecting her mobility, so grab bars were initiated. Verified the resident had no falls since the perimeter mattress was placed and the resident had two falls due to being in bed asleep. Also verified no documentation in the resident's record indicating the perimeter mattress was affecting her mobility and the Restraint Enabler Decision Tree completed with the resident was not inclusive for fall prevention. Also confirmed the plan of care for at risk for falls for this resident had the perimeter mattress resolved with the grab bars placed as an intervention under the plan of care for mobility and not for fall prevention. Interview on 02/12/26 at 8:51 A.M. with Physical Therapy Assistant #1026 revealed she completed the therapy screening on 02/09/26 for Resident #41 for mobility and not for fall prevention. Also verified Resident #41 had been receiving occupational therapy which includes bed mobility and there were no concerns with the perimeter mattress affecting her mobility. In her professional opinion, grab bars are for resident mobility and can be for fall prevention, but this resident is falling out of bed while asleep, therefore, the grab bars are for mobility and not fall prevention.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interview, the facility failed to implement the antibiotic stewardship policy to ensure antibiotics were prescribed appropriately. This affected three of three residents reviewed for antibiotic use (Residents #2, #5, and #33). The facility census was 74. Findings include: 1. Review of the record for Resident #5 revealed an admission date of 08/26/25 with diagnoses including malignant neoplasm of the urethra, chronic kidney disease, and obstructive and reflux uropathy. The resident had an indwelling catheter. Review of physician progress notes on 02/11/26 revealed the resident was transferred to the emergency room this morning after her catheter was found dislodged in her bed with the balloon still inflated. She reports that the catheter was likely accidentally pulled out. The facility staff are not permitted to replace the catheter due to her cancer diagnosis, so she went to the emergency room for replacement. The catheter was successfully replaced. A urinalysis showed large amounts of blood and leukocytes and she was diagnosed with a urinary tract infection (UTI). She was discharged back to the facility on Cefuroxime (antibiotic) 250 milligrams two tablets every 12 hours for seven days. She reports pain only when the catheter was being manipulated but otherwise feels fine. Review of a physician progress note on 02/13/26 revealed the resident continued on the antibiotic and denied dysuria, fever, flank pain, chest pain, or dyspnea. The note stated the urine culture and sensitivity results were pending. Will adjust antibiotic treatment if necessary based on culture results. Review of urine culture results obtained on 02/14/26 revealed 50,000-100,000 CFU/ML of pseudomonas aeruginosa and 10,000-50,000 CFU/ML pseudomonas aeruginosa. The results did not list Cefuroxime as an antibiotic effective against the bacteria. Review of an antibiotic stewardship evaluation completed by the facility 02/12/26 revealed the UTI did not meet the McGeer's criteria. (to meet McGeers criteria, must be symptomatic and have a urine culture with > 10 to the fifth power (>100,000)CFU/ML of any organisms). However, the antibiotic was continued. Physician response for use of treatment stated: due to her medical condition of bladder cancer, not treating current symptoms would risk further complications. It did not indicate what physician gave the response or what the symptoms were that would risk further complications. Interview with Regional Director of Clinical Services #1050 on 02/17/26 at 1:09 P.M. confirmed the antibiotic Resident #5 was receiving was not listed on the urine culture sensitivity to indicate if the the bacteria was sensitive to that medication. She confirmed the urine culture did not show > 100,000 bacteria as required by the McGeers criteria. She confirmed the antibiotic stewardship evaluation completed 02/12/26 did not indicate what physician gave a response or what symptoms were present. 2. Review of the medical record for Resident #2 revealed an admission date of 02/07/26 and diagnoses including diabetes and chronic kidney disease. He had an indwelling catheter. He had a physician's order upon admission [DATE] for an antibiotic (Keflex) 500 milligrams every six hours for 10 days for UTI. On 02/07/26 an antibiotic stewardship evaluation was completed by the facility which stated he had a UTI with onset date of 02/07/26. Not experiencing pain related to the infection. No other urinary symptoms were documented. It further stated he had repeated oral temperature of 99 degrees Fahrenheit. It stated he met the McGeers criteria due to the fevers and a urine culture with at least 10 to the fifth power of any organism. Review of the urine culture results dated 02/09/26 revealed > 100,000 CFU/ML of proteus mirabilis. The sensitivity report did not include Keflex to determine if the bacteria was sensitive to that antibiotic. The facility provided documentation that stated that the effectiveness of Keflex is not guaranteed against UTI's and depends heavily on local resistance patterns. It stated urine culture and sensitivity testing is crucial before prescribing. Recent guidelines often favor alternative antibiotics over Keflex due to variable efficacy and resistance concerns. The Keflex was given until 02/14/26 (7 days out of 10) when it was discontinued due to the resident having diarrhea. He was then started on a different antibiotic (Doxycycline) due to chest xray results indicating pneumonia. On 02/15/26 at 5:19 A.M. nursing progress notes stated he returned (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from the emergency room where he was diagnosed again with a UTI. He was started on an antibiotic (Bactrim DS) 800-160 mg twice daily for five days. Interview with the Director of Nursing on 02/19/26 at 8:00 A.M. revealed she marked the antibiotic stewardship evaluation in error as Resident #2 did not have repeated oral temperatures of 99 degrees. She stated he had one temperature of 99.5 degrees on 02/07/26 but no other elevated temperatures. She confirmed there was no evidence the physician reviewed the use of Keflex when it was not listed on the urine culture sensitivity as effective against the bacteria. 3. Review of the medical record for Resident #33 revealed an admission date of 01/08/26 and diagnoses including diabetes and hypertension. On 01/15/26 the resident was sent to the emergency room. Hospital records on 01/15/26 stated the resident had decreased urinary output with concerns for kidney injury. States burning urinary pain. Has catheter. However the notes further stated denies abdominal or flank discomfort, fevers, chills, hematuria, or dysuria. The resident was started on an antibiotic (Macrobid) 100 milligrams twice daily for five days for UTI. The medication was given for five days as ordered. A physician progress note on 01/15/26 stated will continue Macrobid as prescribed. Follow up on urine culture results to ensure appropriate antibiotic coverage. Review of urine culture results on 01/19/25 indicated 10,000-50,000 CFU/ML of pseudomonas aeruginosa and escherichia coli. (not > 100,000 as required to meet McGeers criteria). Interview with the Director of Nursing on 02/19/26 at 8:00 A.M. revealed an antibiotic stewardship evaluation was not completed for the use of Macrobid on 01/15/26. She further confirmed there was no evidence of follow up by the physician on the use of the Macrobid when urine culture results did not support the use of an antibiotic. Review of the facility policy on Infection Prevention and Control Program dated October 2025 revealed McGeer criteria is used for infection surveillance. Review of the Antibiotic Stewardship policy dated October 2025 revealed the purpose of the the antibiotic stewardship program was to monitor the use of antibiotics. It stated when a culture and sensitivity is ordered, lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued.