

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365747	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2025
NAME OF PROVIDER OR SUPPLIER Astoria Place of Waterville		STREET ADDRESS, CITY, STATE, ZIP CODE 555 Anthony Wayne Trail Waterville, OH 43566	
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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, county coroner interview, review of the Emergency Medical Services (EMS) run report, review of the death certificate, and review of the facility self-imposed action plan, including in-service records and audits, the facility failed to provide residents food in the correct texture to meet individual needs, failed to ensure residents were provided feeding assistance/supervision as required, and failed to put monitoring systems in place to prevent the same actions, situations, and/or practices from reoccurring. This resulted in Immediate Jeopardy for one (#83) resident who experienced serious life-threatening harm and negative health outcomes resulting in death when served the incorrect food item at snack time, subsequently choked, lost consciousness, and collapsed, requiring staff intervention to perform cardiopulmonary resuscitation (CPR), and an emergency medical service response in an effort to remove the food bolus from the trachea where it was preventing air flow to and from the lungs. Additionally, a second resident (#07) was placed at risk for potential serious life-threatening adverse outcomes when Resident #07 who was observed eating alone in his room, coughing with urgency, with a purple/red discoloration to his face, requiring facility staff to be alerted by a surveyor, and staff intervention to dislodge food. This affected one (#83) of three residents reviewed for mechanically altered diets and one (#07) of three residents reviewed for activities of daily living who required assistance/supervision with eating. The facility identified 17 residents (#14, #20, #46, #03, #49, #53, #55, #56, #57, #01, #07, #62, #79, #82, #64, #65, and #72) who were ordered mechanically altered diets, and seven residents (#05, #07, #33, #41, #53, #64 and #78) who required feeding assistance/supervision. The facility census 74. On 08/06/25 at 4:02 P.M., Corporate Chief Nursing Officer (CCNO) #401, [NAME] President of Clinical (VPC) #400, Regional Director of Operations (RDO) #402, and the Director of Nursing (DON) were notified Immediate Jeopardy began on 09/30/24 at 9:26 P.M. when Resident #83 was served a peanut butter sandwich, sometime around 8:00 P.M., as an evening snack by Certified Nursing Assistant (CNA) #320, contrary to the resident's physician order for a regular diet, mechanical soft, thin consistency, no bread, and no straws. Sometime later, CNA #320 responded to Resident #83's roommates call light and found Resident #83 on the floor, and unresponsive. CNA #320 summoned Registered Nurse (RN) #366 for help. RN #366 began CPR as Resident #83 had no pulse or respirations. Emergency Medical Services (EMS) were called and arrived at 8:47 P.M., EMS took over CPR. Resident #83 remained without a pulse or respirations. At 8:53 P.M., EMS attempted to place a breathing tube, and a foreign body was noted in Resident #83's mouth, the foreign body appeared to be chewed food. Resident #83 was suctioned and about five milliliters (ml) of product was removed. Continued efforts to resuscitate Resident #83 were unsuccessful and Resident #83's death was pronounced at 9:26 P.M. The Immediate Jeopardy was removed on 08/07/25 at 2:12 P.M. when the facility implemented the following corrective actions: On 08/06/25 at 4:30 P.M., a root cause analysis was conducted by the following team members: the Administrator, DON, RDO #402, and CCNO #401 and VPC #400 to determine why residents were not provided with food prepared in a form designed to meet individual needs and why residents were not (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 365747
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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	provided the level of supervision when eating as ordered. On 08/06/25 at 4:45 P.M., a Quality Assurance Assessment (QAA) meeting was held which included the Administrator, Executive Director, DON, RDO #402, and the Medical Director. The team discussed a plan to mitigate resident choking incidents. The plan outlined included the following: - Identifying on the resident's meal ticket, the diet ordered, and the resident's required level of assistance with eating, including supervision. Resident diet orders and level of assistance with eating will be managed by the clinical team, with any changes to the diet order or a resident's level of assistance communicated to the Dietary Manager by the clinical team at the time of the change. - The Dietary Manager, on a daily basis, will ensure resident meal tickets are up to date with the resident's current diet and level assistance or need for supervision with eating. The Dietary Manager will also place a list of resident diet orders, including diet texture, level of assistance or supervision needed on the snack carts, and all snacks will be labeled to identify the diet texture type. On 08/06/25 at 5:00 P.M., the Department Managers initiated education with the staff on-duty; five Registered Nurses (RN), 15 Licensed Practical Nurses (LPN), three laundry aides, five housekeepers, nine dietary staff, four activities staff, one Executive Director (ED), one DON, one Assistant Director of Nursing (ADON), five therapy staff, one receptionist, one social service employee, 23 CNAs, and one transportation person, on the meal ticket containing the resident's diet ordered, and the required level of assistance with eating, including supervision, each snack on the snack cart labeled with appropriate diet texture, the snack cart containing a list of resident's current diet orders, including texture, required level of supervision or feeding assistance needed with snacks. Staff are to refer to the diet order list prior to offering a snack to each resident. The education with on-duty staff was completed on 08/06/25 at 10:04 P.M. Staff who were not present for the education on 08/06/25 were sent education via text message, with a requirement to send confirmation of the education received. Staff were to respond to the text with a Y for yes, indicating the staff had received and understood the education. Employees would not be able to work until education was completed. Education for all facility staff was completed on 08/07/25 at 2:12 P.M. On 08/06/25 at 6:00 P.M., CCNO #401 and VPC #400 completed a review of all resident diet orders and made sure resident care plans reflected diet and functional status (level of assistance/supervision with eating). On 08/06/25 at 6:00 P.M., the Dietary Manager updated all meal tickets to reflect the correct diet and level of assistance or supervision with meals a resident needed. On 08/07/25 at 2:12 P.M., the education for all facility staff was completed. On 08/07/25, the Administrator completed an audit of three meals and a snack with no negative findings. Continued random meal and snack audits will be conducted by the Administrator or designee, three times a day for five days for one week, then one meal and a snack will be audited five days a week for three weeks. Results of audits will be reviewed in Quality Assurance meetings. Any identified non-compliance will be addressed immediately by the Administrator or DON. Although the Immediate Jeopardy was removed on 08/07/25, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: 1. Review of the medical record for Resident #83 revealed an admission date of 03/10/20. Diagnoses included paranoid schizophrenia, major depressive disorder, obstructive and reflux uropathy, dysphagia, type II diabetes mellitus, bipolar disorder, histrionic personality disorder, psychophysical visual disturbances, and auditory hallucinations. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #83 was cognitively intact, independent for eating with set-up, had no signs or symptoms of a swallowing disorder and received a mechanically altered diet. Review of care plan dated 09/12/23 for Resident #83 revealed the resident was a full code status (CPR should be initiated with the absence of pulse, respirations, and/or blood pressure). The care plan also revealed a swallowing problem related to a diagnosis of dysphagia with interventions that included for all staff to be informed of the resident's special dietary and safety needs, follow diet as prescribed, instruct the resident to eat in an upright position, to eat slowly and (continued on next page)		

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	death. RN #366 was told by CNA #320 that Resident #83 was given a sandwich by CNA #386. RN #366 confirmed Resident #83 was not to receive bread and had a physician order for no bread. Interview on 08/12/25 at 6:26 A.M. with CNA #386 revealed that on 09/30/24 at approximately 8:30 P.M. the call light was going off in Resident #83's room and when she got there, RN #366 was performing CPR. CPR was performed by nursing staff until EMS showed up. About 30 minutes prior to the call light CNA #386 confirmed that Resident #83 was given a peanut butter sandwich by her. CNA #386 indicated she always checks with whatever nurse is on duty before passing any food but does not remember if she checked that night. Review of the facility self-imposed action plan initiated 10/01/24 revealed the following: On 10/01/24 at 9:00 A.M., a Quality Assurance Assessment (QAA) meeting was held which included the Administrator, DON, RDO #402 and the Medical Director. The team discussed a plan to mitigate the choking incident. The plan implemented included a list of diet textures on the snack cart. Staff education was completed communicating the diet texture list would be placed on the snack cart. On 10/01/24, the DON, Assistant Director of Nursing (ADON), and Unit Manager completed audits on all current resident records, including resident observations during snack pass to ensure residents received the appropriate textured snacks. Observations started at 9:30 A.M. and finished at 11:00 A.M. On 10/01/24 at 11:30 A.M., the Dietary Manager printed a list of the residents' diets and verified the list matched the resident's current diet order. The list would be sent with the snack carts so the CNAs could identify what diet each resident was on. Diet orders were to be up to date at all times with the Dietary Manager verifying each day when printing the list. On 10/01/24 at 11:30 A.M., seven RNs, 15 LPNs, 36 CNAs, nine dietary employees, eight housekeeping and laundry employees, three activities employees, two receptionists, one scheduler, one Human Resources person, one Social Service employee, one admission staff, one maintenance employee, and one medical record staff member were educated by the DON, ADON and Unit Manager to ensure the diet list printed was being referenced prior to serving a resident a snack from the snack cart. Education was completed at 12:45 P.M. On 10/02/24, ongoing audits were started and completed by way of staff interview to ensure staff reviewed the resident diet list prior to snacks offered to the resident, and that the current diet list was available on the snack tray. Audits were completed three times a week for four weeks by the ADON. Compliance was determined on 10/28/24. 2. Review of the medical record revealed Resident #07 was admitted on [DATE]. Diagnoses included chronic kidney disease, epilepsy, and overactive bladder. Review of Resident #07's physician orders, dated 04/04/25, revealed the physician prescribed a regular diet, pureed texture, and nectar consistency. Review of the quarterly MDS assessment, dated 07/11/25, revealed the resident had severe cognitive impairment and required substantial assistance for feeding. Review of the nutritional assessment, dated 07/17/25, indicated Resident #07 was to be supervised while eating. Observation on 08/06/25 at 8:07 A.M. while confirming environmental issues in the residents' rooms with Regional Director of Maintenance #403 revealed coughing coming from Resident #07's bedroom. No staff were present during this time. Resident #07's cough began to sound more urgent, the surveyor went into Resident #07's room and noted Resident #07 with a food tray in front of him. Resident #07 was coughing and had a purple/red discoloration to his face. The surveyor went into the hallway and yelled for help. LPN #381 and CNA #323 went into Resident #07's bedroom and assisted him in clearing the food by sitting him up in the bed manually due to the bed not working. Resident #07 was sitting at approximately a 60-degree angle. Interview on 08/06/25 with LPN #381 revealed herself and CNA #323 had to sit Resident #07 up in bed because the bed position was stuck. LPN #381 further stated with repositioning that the food was able to be dislodged and Resident #07 spit the food into a towel. Interview on 08/06/25 at 10:28 A.M. with ADON #370 revealed Resident #07 coughed up his food and spit it in a towel. ADON #307 confirmed that the most recent nutritional assessment on 07/17/25 stated Resident #07 was to be supervised while eating. Furthermore, the ADON confirmed the MDS indicates Resident #07 requires substantial assistance for feeding. Interview with CNA #323 on 08/06/25 at 10:45 A.M. revealed Resident #07 had choked on his oatmeal on 08/04/25 and was able to clear it himself. (continued on next page)		

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Furthermore, CNA #323 stated typically Resident #07 is left unsupervised when eating in his room. Interview on 08/06/25 at 11:18 A.M. with Dietetic Technician #415 stated there are varying levels of set up and supervision that Resident #07 may need; however, if Resident #07 had a choking episode on 08/04/25, then the episode should have been reported, and Resident #07 should have been evaluated by speech therapy. Review of the Facility Assessment, dated 06/17/25, indicated the facility will meet individualized dietary requirements, including specialized diets to ensure the resident's nutritional requirements are met. The staff training and education provided annually and as needed to ensure the level of support and care needed for the resident population included nutritional promotion in older adults, diets in long term care, and feeding and eating assistance. Review of the undated facility policy titled Therapeutic Diets, identified therapeutic diets shall be prescribed by the attending physician. Mechanically altered diets are identified as therapeutic. The Dietician and Dietary Manager are responsible to record in the resident's medical record significant information related to the resident's therapeutic diet. A tray identification system is utilized to ensure each resident receives the correct diet. Review of the undated facility policy titled Reading Meal Tickets/Cards, revealed all staff will read and review the meal ticket/card, including any meal alteration for consistency, to ensure residents are served the correct meal or snack. Review of the facility policy titled Activities of Daily Living, revised January 2022, stated ADL services are directed toward the goal of promoting the highest practicable physical, mental and psychological functioning of the resident. ADL care plans are developed by a nurse and may be delivered by the designated staff members as part of routine care with a facility goal that a resident's abilities do not diminish. ADL care areas include bathing, dressing/grooming, toileting, mobility, transfers and eating. Staff are to follow the resident's care plan when carrying out the ADL task and inform the nurse when there is a refusal or significant decline in the resident's abilities. This deficiency represents non-compliance investigated under Complaint Number OH00166789 (1260025).		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, review of a job description, and policy review, the facility failed to provide adequate administration over the facility when a resident died from a choking incident as a result of being provided unapproved food items. The facility subsequently put a corrective action plan into place that was not fully followed to prevent further episodes of resident's choking and prevent residents from receiving restricted food and drinks. This had the potential to affect all 74 residents residing in the facility. The facility census was 74. Findings Include: Interview on 08/12/25 at 1:47 P.M. with the Administrator, Chief Nursing Officer (CNO) #401, and [NAME] President of Clinical Services (VPCS) #400 revealed after a choking incident on 09/30/24 that resulted in a resident's (#83) death when the resident was give food items that were restricted, the facility immediately implemented a self-imposed action plan (SIAP) to correct the deficiencies that contributed to the event. Part of the SAIP included an entry dated 10/01/24, that the Dietary Manager (DM) would put a diet list on each snack tray so staff are aware of the current diet order prior to offering a snack. Additionally, the SAIP included on 10/01/24 staff education on the diet list would be completed by the Director of Nursing (DON)/Assistant Director of Nursing (ADON) #370/Clinical Manager (CM) with audits being done to observe staff were utilizing the cards. The SIAP also indicated the results of the audits will be reported to the Quality Assurance (QA) committee. Random observations made throughout the survey revealed staff not utilizing diet order cards on snack trays during snack pass times; and additional observations made throughout the annual survey revealed on 08/06/25 at 10:27 A.M. Resident #7 was choking on food while eating in bed and staff came to assist with the resident ultimately coughing up food into a towel. Resident #7 was eating alone at the time of the choking incident and review of a nutritional assessment dated [DATE] revealed the resident was to be supervised while eating. Interview on 08/06/25 at 10:28 A.M. with ADON #370 revealed Resident #07 coughed up his food and spit it in a towel. ADON #307 confirmed that the most recent nutritional assessment on 07/17/25 stated Resident #07 was to be supervised while eating. Further observation on 08/11/25 at approximately 9:05 A.M. revealed Resident #38 eating bacon from another resident's meal tray off the unattended hallway cart, and review of Resident #38's physician order dated 01/16/25 revealed the resident a regular diet with pureed texture and thin liquids. Interview on 08/11/25 at approximately 9:07 A.M. with VPCS #400 confirmed Resident #38 had bacon. Interview on 08/11/25 at 9:08 A.M. with Certified Nurse Aide (CNA) #404 confirmed Resident #38 regularly took food from other residents' plates. Staff had to monitor Resident #38 closely because of this behavior. Further interview revealed CNA #404 was in the dining room during the observation at approximately 9:05 A.M. when Resident #38 removed bacon from the tray cart. CNA #404 confirmed Resident #38 was on a pureed diet. Further, CNA #404 confirmed the tray Resident #38 removed the bacon from was an untouched tray for a resident who was hospitalized. Review of the undated Executive Director (Administrator) job description listed essential job functions and responsibilities included to develop and maintain written policies and procedures that govern the operation of the facility, and assume the administrative authority, responsibility, and accountability of directing the activities and programs of the facility. Additionally, the primary purpose of job description was to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern long-term care facilities to assure that the highest degree of quality of care can be provided to our residents at all times. Review of the Quality Assurance Performance Improvement (QAPI) policy, dated 03/2023, revealed governance and leadership will operate under the direction of the QAPI Governing Chairpersons who are considered subject matter experts; Executive Director, Director of Nursing, Medical Director, and Infection Preventionist. Further, the policy revealed the object of the QAPI Governing was to develop a continuous pro-active approach to self-discovery to decrease the likelihood of issues/concerns and test new approaches to correct (continued on next page)		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	underlying potential causes of those issues/concerns. This deficiency represents non-compliance investigated under Complaint Number 2562969.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of water flushing logs, review of water monitoring logs, review of water temperature logs, staff interview, review of a water pH level reading document, and policy review, the facility failed to accurately and adequately conduct water monitoring for the prevention of Legionella within the facility. This had the potential to affect all 74 residents in the facility. The census was 74. Findings include: Review of the water flushing logs from January 2025 through August 2025 revealed no water lines were flushed in January, February, and March 2025. A comment written on the log for March 2025 revealed, all rooms in use 03/14/25. Further review revealed room [ROOM NUMBER] was flushed on 05/06/25 (marked as completed late for April 2025), room [ROOM NUMBER] was flushed on 05/16/25, 06/05/25, and 07/22/25, and room [ROOM NUMBER] was flushed on 08/04/25. Further review revealed no specifics regarding the faucet that was flushed or the duration of the flush. Review of the chlorine and pH monitoring levels in drinking water, dated 04/11/25, revealed A-hall and C-hall had pH levels of five (5) and B-hall had a pH level of four (4). Review of the chlorine and pH monitoring levels in drinking water, dated 06/06/25 and 06/18/25, revealed A-hall, B-hall, and C-hall had pH levels of 4.0 and chlorine levels of 1.0. Review of the water temperature logs from 05/01/25 through 08/12/25 revealed no water temperatures were obtained and documented between 06/21/25 and 07/17/25 and between 07/19/25 and 08/04/25. Interview on 08/12/25 at 7:36 A.M. with Regional Director of Maintenance (RDM) #403 revealed the facility had no assigned maintenance director and RDM #403 was covering the facility until someone was hired for the position. RDM #403 stated and he expected staff to monitor water temperatures by checking at least two rooms from each hall, preferably one room at each end, and to vary the rooms. Further interview revealed unused water sources were flushed for ten (10) minutes, once monthly, to deter Legionella growth. Additionally, RDM #403 stated the facility tested pH and chlorine levels once monthly. Interview on 08/12/25 at approximately 8:00 A.M. with the Administrator revealed the facility had no empty rooms on 08/12/25 and often did not have empty rooms. Follow-up interview on 08/12/25 at 10:25 A.M. with RDM #403 confirmed he should be flushing unused faucets once weekly to deter the growth of Legionella rather than only once monthly as had been his practice at the facility. Further, RDM #403 confirmed water temperatures should be checked daily and confirmed no water temperatures were completed between 06/21/25 and 07/17/25 and between 07/19/25 and 08/04/25. Follow-up interview on 08/12/25 at 10:53 A.M. with RDM #403 confirmed a pH of 4.0 or 5 was not appropriate for drinking water and RDM #403 verified drinking water should have a pH of 6.5 to 8.5. RDM #403 provided a printed internet search regarding the average pH of drinking water and verified it could be used as the facility's policy regarding the appropriate pH range of drinking water. The facility was unable to provide any guidance regarding the optimal level of chlorine in drinking water. Review of the document titled, Standards for water pH readings, printed from the internet on 08/12/25 at 10:50 A.M., revealed the standard range for pH in drinking water, as recommended by the Environmental Protection Agency, was between 6.5 and 8.5. Review of the undated policy titled, Legionella Policy - Environmental, revealed the implement measures to reduce the potential for the growth and spread of Legionella. Control measures would include, but were not limited to routine testing of chlorine levels, routine testing of water temperature levels, and monitoring and flushing pipes in rooms and/or areas of the building that were not in use.		

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

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on employee file review and staff interview, the facility failed to ensure employees completed Quality Assurance and Performance Improvement (QAPI) training. This had the potential to affect all 74 residents residing in the facility. The facility census was 74. Findings include: Review of the employee file for Certified Nurse Aide (CNA) #320, CNA #306, CNA #305, Licensed Practical Nurse (LPN) #383, and Registered Nurse (RN) #365 revealed none of the employees received training on the facility's QAPI program. Interview on 08/12/25 at 8:00 A.M. with CNA #371, LPN #381 on 08/12/25 at 10:10 A.M., and CNA #219 on 08/12/25 at 10:12 A.M. revealed none of the three staff members were aware of what QAPI was and had not been trained on it. Interview on 08/12/25 at 2:00 P.M. with Human Resource Manager #379 confirmed employees should have QAPI training upon hire and confirmed CNA #320, CNA #305, CNA #306, LPN #383, and RN #365 had no evidence of QAPI training in their employee files.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and staff interview, the facility failed to ensure the facility maintained a homelike environment. This affected eight (#35, #82, #22, #36, #12, #81, #7, and #29) of eight residents reviewed for environment. The facility census was 74. Findings include: 1. Observation on 08/05/25 at 1:43 P.M. behind Resident #12's bedroom door revealed a large hole in the drywall at the door handle height. Also noted in the coinciding area behind the door right below the ceiling was a small hole in the drywall. In Resident #12's shared bathroom there was a waste basket under the sink, approximately one-quarter full of water. 2. Observation on 08/05/25 at 1:43 P.M. of Resident #81's bedroom revealed a light above his bed with no cord to turn the light on. Resident #81 shared a bathroom with Resident #12 which had a waste basket under the sink, approximately one-quarter full of water. 3. Observation on 08/05/25 at 1:49 P.M. of Resident #7 and Resident #35's room revealed large brown-colored areas of a substance throughout the entire ceiling. 4. Observation on 08/05/25 at 1:51 P.M. of Resident #29's bedroom revealed a light above the bed with no pull cord. 5. Observation on 08/05/25 at 1:52 P.M. of Resident #36 and Resident #22's room revealed large brown-colored areas of a substance throughout the entire ceiling. 6. Observation on 08/05/25 at 1:53 P.M. of Resident #82's bedroom revealed a light above the bed with a broken cover that was hanging from the light. Interview and observation on 08/06/25 at 8:07 A.M. with Regional Director of Maintenance (RDM) #403 confirmed Resident #12 had two holes behind the door and a waste basket under the bathroom sink shared by Resident #12 and Resident #81 that was approximately one-quarter full of water. RDM #403 stated he was going to get a part to fix the sink. RDM #403 also confirmed Resident #81 and Resident #29 did not have pull cords for their lights over their bed. RDM #403 confirmed the ceilings in the room shared by Resident #7 and Resident #35 and the room shared by Resident #36 and Resident #22 had water pipes that burst and were fixed; however, the brown-colored spots on the ceiling were not. Additionally, RDM #403 confirmed Resident #82's light was broken. This deficiency represents non-compliance investigated under Complaint Number 2562969 and Complaint Number OH00166789 (1260025).		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident and staff interview, review of shower schedules, and review of facility policies, the facility failed to ensure residents had the right to choose when they receive their medications to prevent refusal and choose the time they shower. This affected two (#50 and #47) of two residents reviewed for choices. The facility census was 74. Findings include: 1. Review of the medical record for Resident #47 revealed an admission of 06/10/25. Diagnoses included schizoaffective disorder, type two diabetes mellitus, and major depressive disorder. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #47 had severe cognitive impairment. Review of the care plan dated 06/17/25 revealed Resident #47 received psychoactive medication due to alteration in mood and behavior. Resident #47 used psychotropic medication related to schizoaffective disorder. The nurse was to administer medications as ordered. Additional review of the care plan revealed Resident #47 had diabetes mellitus. The nurse was to administer medications as ordered by the doctor and monitor for its effectiveness. Resident #47 had chronic obstructive pulmonary disease (COPD). The nurse was to give aerosol or bronchodilators as ordered. Review of the physician orders for Resident #47 revealed orders for aspirin 81 milligrams (mg) daily in the morning for a preventative, fenofibrate 48 mg one tablet in the morning for hyperlipidemia, furosemide 20 mg one tablet by mouth in the morning for hypertension, Incruse ellipta 62.5 micrograms (mcg) aerosol powder, breath activated one inhalation inhale orally in the morning for respiratory, Lantus insulin subcutaneous solution pen-injector to inject 25 units subcutaneously in the morning for diabetes mellitus type two, levothyroxine 100 mcg by mouth every morning for hypothyroidism, lisinopril 20 mg by mouth every morning for hypertension, metformin 1000 mg by mouth in the morning for diabetes type two, metoprolol 50 mg by mouth in the morning for hypertension, risperidone two (2) mg by mouth in the morning for schizoaffective disorder, Seroquel 100 mg by mouth in the morning for schizoaffective disorder, and Humalog insulin subcutaneous solution pen injector to inject five (5) units subcutaneously with meals for diabetes mellitus along with sliding scale. Review of the medication administration record (MAR) for Resident #47 revealed on 08/04/25 all morning medications were refused. Review of the progress notes dated 08/04/25 at 3:35 A.M. revealed the nurse offered Resident #47 his morning medication a half hour before the progress note was written and Resident #47 refused. Interview on 08/04/25 at 8:15 A.M. with Resident #47 revealed he did not receive his morning medication because the night shift nurse came to his room at 3:00 A.M. to give him his medication and he did not want to take his medication that early. Interview on 08/04/25 at 8:20 A.M. with Licensed Practical Nurse (LPN) #381 revealed the MAR indicated medication can be given early which meant 6:00 A.M. Resident #47 refused his insulin from her due to not receiving his morning medication from the night nurse. LPN #381 stated there was no way for her to administer the medications due to not being able to sign them out since the night shift (continued on next page)		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse marked them as refused. Interview on 08/04/25 at 8:26 A.M. with Assistant Director of Nursing (ADON) #370 revealed the early medication administration was between 4:00 A.M. and 6:00 A.M. The early morning medications may be passed by the night shift nurse, and if she was unable to administer them all, then the day shift nurse can finish the medication administration. ADON #370 confirmed 3:00 A.M. was too early for medications to be administered, and Resident #47 was able to receive medications when requested. Review of the facility policy titled, Medication Administration and Documentation, dated 06/26/24, revealed prior to administering medication the nurse must observe the five rights of medication administration which include the right time, verifying that this is the appropriate time for the medication. 2. Review of the medical record for Resident #50 revealed an admission date of 06/20/17. Diagnoses included generalized anxiety disorder, major depressive disorder, and paranoid schizophrenia. Review of the quarterly MDS assessment dated [DATE] revealed Resident #50 had intact cognition. The resident was dependent on staff for bathing and showering. Review of the shower schedule revealed Resident #50 had showers scheduled for Wednesdays and Saturdays on the 12-hour evening shift. Review of the shower task documentation and shower sheets revealed no documentation Resident #50 received showers per her choice on 07/02/25, 07/09/25, 07/16/25, 07/19/25, 07/23/25, 07/26/25, and 07/30/25. Review of the nurses' notes dated 07/10/25 through 08/06/25 revealed no documentation Resident #50 refused any showers. Interview on 08/04/25 at 11:41 A.M., Resident #50 revealed she had not been receiving her showers per her choice on the scheduled shower days. Interview on 08/07/25 at 10:12 A.M., the Director of Nursing (DON) verified there was no documentation Resident #50 had received showers per choice as scheduled on 07/02/25, 07/09/25, 07/16/25, 07/19/25, 07/23/25, 07/26/25, and 07/30/25. Review of the facility policy titled, Bathing Choice Policy, revised 01/01/25, revealed resident's had the choice of bathing frequency.		

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of a personal funds balance statement, staff interview, and policy review, the facility failed to ensure a resident was provided notification of spend down when personal funds were within \$200.00 of the resource limit. This affected one (#51) of eight residents reviewed for personal fund accounts. The facility identified 41 residents with personal funds accounts. The facility census was 74. Findings include: Review of the medical record for Resident #51 revealed an admission date of 05/17/22. Diagnoses included schizophrenia, chronic obstructive pulmonary disease, and peripheral vascular disease. Resident #51's primary payer source was Medicaid. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 had intact cognition. Review of Resident #51's trial balance fund dated 08/11/25 revealed the resident had a personal funds account balance of \$2,293.28. Interview on 08/11/25 at 4:42 P.M. Chief Nursing Officer Registered Nurse (CNORN) #401 verified the facility had no evidence Resident #51 or the resident representative were provided a notification of spend down when the resident was within \$200.00 of reaching the \$2,000.00 resource limit. Review of the facility policy titled, Managing Resident Personal Funds, revised 07/2025, revealed accumulations above \$2,000.00 in a resident personal account may get the resident removed from Medicaid rolls until the money is spent down. The allowable amount set by the state currently was \$2,000.00 and the facility would notify the resident when they were within \$200.00 of the state limit.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of hospital documentation, review of self-reported incidents, staff interview, and policy reviews, the facility failed to ensure appropriate notifications were made for three (#1, #71, and #56) of seven residents reviewed for resident-to-resident interactions and change in condition. The facility census was 74. Findings include: 1. Review of the medical record for Resident #1 revealed an admission date of 05/27/25 with diagnoses of anoxic brain damage, dementia, bipolar disorder, and schizoaffective disorder. Review of the comprehensive admission Minimum Data Set (MDS) assessment, dated 06/03/25, revealed Resident #1 had impaired cognition and impairment to one side of her upper extremity and one side of her lower extremity. Review of the medical record for Resident #71 revealed an admission date of 01/04/22 with diagnoses of neurocognitive disorder, with Lewy bodies, stroke, pseudobulbar affect, dysarthria and anarthria. Review of the quarterly MDS assessment, dated 06/14/25, revealed Resident #71 had impaired cognition, had no impairment to the upper or lower body, used a wheelchair for mobility, was dependent for toileting, required substantial/maximal assistance for sit-to-stand transfers and walking, and was dependent for mobilizing in her wheelchair. Review of the facility's self-reported incident (SRI), Tracking #263493, revealed the facility initiated an SRI for physical abuse when Resident #71 was found lying on the ground in Resident #1's room on 07/30/25. Resident #1 stated she hit Resident #71 because Resident #71 was in her room. The facility determined abuse did not occur as a result of their investigation. Review of the facility's investigation into the incident revealed both residents were assessed for injuries and neither resident was injured. Further review revealed the physician and the manager on duty were notified of the incident. The investigation provided no indication the resident representative for either resident was notified. Interview on 08/12/25 at 6:45 A.M. with Registered Nurse (RN) #366 revealed she was the nurse on duty during the time of the incident between Resident #1 and Resident #71. RN #366 confirmed she did not notify the resident representative for Resident #1 because RN #366 believed Resident #1 had a guardian who was not very involved in Resident #1's care. RN #366 further stated she did not notify Resident #1's representative because Resident #1 was her own person. Review of the facility's abuse policy, reviewed 05/2025, revealed the resident representative, and the resident's attending physician, if appropriate, should be notified of the incident/allegation. 2. Review of the medical record for Resident #56 revealed an admission on [DATE] with diagnoses of paranoid schizophrenia, major depressive disorder, and pseudobulbar affect. Review of the admission MDS assessment dated [DATE] revealed Resident #56 was cognitively intact. Further review of the MDS revealed Resident #56 used a walker to ambulate and required (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supervision for activities of daily living (ADLs). Review of the care plan dated 07/15/25 revealed Resident #56 was at risk for falls and potential injury related to psychoactive drug use, and staff were to minimize the potential risk factors related to falls. Additional review of the care plan revealed Resident #56 used psychotropic medications related to paranoid schizophrenia, major depressive disorder, and anxiety disorder. Resident #56 was to remain free of drug related complications including gait disturbances. Staff were to report any adverse reactions, including unsteady gait or shuffling gate. Review of the progress note for Resident #56 on 08/11/25 at 6:17 P.M. revealed at 6:15 P.M. Resident #56 was observed running up and down the hallway. Resident #56 had been hallucinating stating the Federal Bureau of Investigation (FBI) was watching her though the walls. Resident #56 believed she needed electric shock therapy. The physician was notified. Review of the progress note for Resident #56 on 08/11/25 at 7:09 P.M. revealed emergency medical services (EMS) was called and Resident #56 was sent out for psychiatric evaluation. Review of the hospital discharge report for Resident #56 on 08/11/25 revealed the resident arrived to the emergency department at 7:40 P.M. A psychiatric evaluation was complete and Resident #56 was discharged with no new orders. Review of the progress note for Resident #56 on 08/12/25 at 3:20 A.M. revealed Resident #56 returned to the facility with no new orders. Interview on 08/12/25 at 10:57 A.M. with Chief Nursing Officer (CNO) #401 confirmed there was no documentation that Resident #56's representative was notified of her recent hospitalization. Furthermore, CNO #401 confirmed the nurse should have contacted Resident #56's representative when she was sent to the hospital and upon return. Review of the policy titled, Notification of Change in Condition, updated 06/2025, revealed the nurse would consult with the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications).		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interview, and policy review, the facility failed to ensure an appropriate diagnosis for the use of an antipsychotic medication. This affected one (#6) of five residents reviewed for unnecessary medications. The facility identified 38 residents as receiving antipsychotic medications. The facility census was 74. Findings include: Review of the medical record revealed Resident #6 had an admission date of 04/02/25. Diagnoses included conversion disorder with seizures or convulsions, dementia, Alzheimer's disease, and depression. Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 had impaired cognition. Review of a physician order dated 04/02/25 revealed Resident #6 had an order for olanzapine 2.5 milligrams by mouth at bedtime for antipsychotic. Further review of the medical record revealed no documentation of a supporting diagnoses for the use of the antipsychotic medication olanzapine. Interview on 08/06/25 at 1:47 P.M., MDS Licensed Practical Nurse (MDS LPN) #315 revealed Resident #6 had no supporting diagnoses for the use of the antipsychotic medication. Review of the facility policy titled, Psychoactive/Antipsychotic Drugs, revised 01/2021, revealed all residents receiving psychoactive medication would be evaluated for necessity of the drug use per OBRA (Omnibus Budget Reconciliation Act) '90 psychoactive drug monitoring schedule. If appropriate diagnoses to support psychotropic drug use are not on the cumulative diagnosis list, the nurse would contact the physician for appropriate diagnosis or clarification.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interview, and policy review, the facility failed to ensure baseline care plans were developed within 48 hours of admission. This affected three (#52, #15, #53) of 31 residents reviewed for baseline care plans. The facility census was 74. Findings include: 1. Review of the medical record revealed Resident #52 had an admission date of 01/10/25. Diagnoses included dementia, depression, anxiety, hypertension, and hemiplegia affecting left non-dominant side. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #52 had intact cognition. Review of Resident #52's medical record revealed there was no baseline care plan initiated within the first 48 hours of admission to the facility. 2. Review of the medical record revealed Resident #15 was admitted on [DATE]. Diagnoses included Parkinson's disease with dyskinesia with fluctuations, type two diabetes mellitus, paranoid schizophrenia, essential hypertension, and hypothyroidism. Review of the MDS assessment, dated 06/28/25, revealed the resident was cognitively intact. Review of the medical record revealed a care plan was not developed until 03/24/25. 3. Review of the medical record revealed Resident #53 was admitted on [DATE]. Diagnoses included major depressive disorder recurrent, bipolar disorder, unspecified psychosis, and cognitive communication deficit. Review of the MDS assessment, dated 05/26/25, revealed the resident was severely cognitively impaired. Review of the medical record revealed baseline care plan was not completed within 48 hours. Interview on 08/12/25 at 9:22 A.M. with [NAME] President Clinical Services #400 verified baseline care plans were not completed timely for Resident #15, #52, and #53. Review of the policy, Care Plan Policy, dated October 2022, verified a baseline care plan will be developed within 48 hours of admission to address the major areas of a resident's care to provide effective person-centered care, to be used until a comprehensive care plan is completed.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to timely develop comprehensive care plans. This affected two (#6 and #16) of 31 residents reviewed for comprehensive care plans. The facility census was 74. Findings include: 1. Review of the medical record for Resident #16 revealed an admission date of 07/09/25 with diagnoses of schizoaffective disorder, chronic obstructive pulmonary disease, and unspecified psychosis. Review of the comprehensive admission Minimum Data Set (MDS) assessment, dated 07/16/25, revealed Resident #16 had intact cognition and used tobacco. Review of the admission packet, dated 07/09/25, revealed Resident #16 smoked, required supervision during smoking, and needed the facility to store his lighter and cigarettes. Further review revealed a care plan for safety revealed Resident #16 was at risk for injury. Goals were to maintain a safe environment during smoking and Resident #16 would comply with facility smoking policy. Review of the facility's list of smokers revealed Resident #16 smoked. Review of the comprehensive care plan for Resident #38, on 08/06/25, revealed no care area for smoking. Interview on 08/06/25 at 5:02 P.M. with the Social Services Designee #392 confirmed care area for smoking was in Resident #16's care plan. SSD #392 stated Resident #16 was a relatively new admission and she had not yet completing adding all care areas to his care plan. 2. Review of the medical record revealed Resident #6 had an admission date of 04/02/25. Diagnoses included conversion disorder with seizures or convulsions, dementia, Alzheimer's disease, and depression. Review of the significant change MDS assessment dated [DATE] revealed Resident #6 had impaired cognition. Review of a physician order dated 04/03/25 revealed Resident #6 was ordered Lexapro ten milligrams in the morning daily for depression. Review of a psychiatry progress note dated 06/19/25 revealed Resident #6 had depressive disorder with recommendations to encourage increased physical activity to improve mood and overall well-being, good sleep hygiene, balanced diet, sunlight exposure, and to practice relaxation techniques Review of Resident #6's care plan, last revised 06/20/25, revealed the resident required psychoactive medication due to alteration in mood and behavior related to behavioral disturbance, and depression. Further review of the care plan revealed there was no care plan in place for the depression diagnosis with individualized interventions. Interview on 08/06/25 at 1:47 P.M. MDS Licensed Practical Nurse (MDS LPN) #315 verified Resident #6 had no care plan in place for depression with individualized interventions. (continued on next page)		

Department of Health & Human Services
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NAME OF PROVIDER OR SUPPLIER Astoria Place of Waterville		STREET ADDRESS, CITY, STATE, ZIP CODE 555 Anthony Wayne Trail Waterville, OH 43566	
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Care Plan Policy, revised 10/2022, revealed a comprehensive care plan would be developed within 21 days after admission upon completion of the appropriate assessments by the Interdisciplinary Team. Overall, care plans would address diagnoses, physician orders, dietary needs, medications, treatments, general care, devices and interventions, behaviors, advanced directives, choices, cultural preferences, and other needs and preferences specific to the resident. The care plan would be used by the care team to coordinate and manage the resident's goals, preferences, choices, past trauma care, and services that would be provided to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, observation, resident and staff interview, and review of facility policy, the facility failed to ensure dependent residents received adequate nail care. This affected two (#40 and #45) of three residents reviewed for activities of daily living. The facility census was 74. Findings include: 1. Review of the medical record revealed Resident #40 was admitted on [DATE]. Diagnoses included unspecified dementia with psychotic disturbance, major depressive disorder recurrent severe with psychotic symptoms, anxiety disorder, Alzheimer's disease, and cognitive communication dysfunctions. Review of the Minimum Data Set (MDS) assessment, dated 06/16/25, revealed Resident #40 was unable to complete the assessment interview. Review of the care plan, revised 01/04/24, revealed Resident #40 had a behavior problem including playing in her own feces. Review of the care plan, revised on 11/11/24, revealed Resident #40 had an activities of daily living (ADL) self-care performance deficit. Interventions includes to check nail length, trim, and clean on bath day and as necessary. Observation on 08/04/25 at 12:02 P.M. revealed Resident #40 had dirty fingerprints with a dark brown substance under all nails on both hands. Observation on 08/05/25 at 3:03 P.M. revealed Resident #40 had dirty fingerprints with a dark brown substance under all nails on both hands. Interview on 08/06/25 at 8:09 A.M. with Registered Nurse (RN) #368 verified Resident #40 does put her hands in her feces. It was reported the resident had a bowel movement three times yesterday and the staff had provided care to the resident immediately. Observation on 08/06/25 at 8:12 A.M. revealed Resident #40 eating breakfast in the dining room. Resident #40 was eating breakfast with her right hand, scooping the food directly into her mouth. Resident #40's fingernails were observed to remain dirty with the left hand fingernails more heavily soiled than the right. Interview on 08/06/25 at 8:14 A.M. with Registered Nurse (RN) #368 verified Resident #40's fingernails were dirty with a dark brown substance and was using her hands to eat breakfast. 2. Review of the medical record revealed Resident #45 was initially admitted on [DATE]. Diagnoses included bipolar disorder, type two diabetes mellitus, hypothyroidism, hyperlipidemia, major depressive disorder, essential hypertension, acute ischemic heart disease, and chronic kidney disease stage three. Review of the MDS assessment, dated 06/09/25, revealed Resident #45 was moderately cognitively impaired and required set-up/clean-up assistance with personal hygiene. Review of the care plan, revised 06/17/25, verified Resident #45 had an ADL self care performance deficit with interventions including to check nail length, trim, and clean on bath day and as necessary. Interview on 08/04/25 at 11:04 A.M. with Resident #45 revealed he would like his fingernails trimmed. Subsequent observation revealed Resident #45's fingernails were longer than typical but clean and not jagged. Observation on 08/07/25 at 2:43 P.M. revealed Resident #45's nails remained long. Subsequent interview with the resident revealed he did not like his nails as long as they were and stated he would like them to be trimmed. Interview on 08/07/25 at 2:46 P.M. with Certified Nurse Aide (CNA) #305 acknowledged Resident #45's fingernails were long and verified Resident #45 indicated he wanted them trimmed. CNA #305 stated it was unknown who normally trimmed Resident #45's nails. Review of the policy titled, Activities of Daily Living, revised January 2022, verified staff will carryout the ADL care tasks following the resident's ADL care plan. This deficiency represents non-compliance investigated under Complaint Number 2562969.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, resident and staff interview, and medical record review, the facility failed to ensure residents received splints and immobilizer devices as ordered by the physician. This affected one (#1) of one residents reviewed for range of motion. The facility census was 74. Findings include: Review of the medical record for Resident #1 revealed an admission date of 05/27/25 with diagnoses of anoxic brain damage, dementia, bipolar disorder, and schizoaffective disorder. Review of the comprehensive admission Minimum Data Set (MDS) assessment, dated 06/03/25, revealed Resident #1 had impaired cognition and an impairment to one side of her upper extremity and one side of her lower extremity. Resident #1 used a wheelchair for mobility. Review of the care plan updated 07/08/25 revealed Resident #1 had limited physical mobility due to decreased range of motion. Interventions included ensuring Resident #1's left arm was in a sling except at bedtime and bathing. Review of a physician order initiated 05/30/25 revealed Resident #1 should receive a Cock-up wrist splint to the left wrist as the resident tolerated with instructions to remove each shift to check skin integrity. Review of a physician order initiated 07/24/25 revealed Resident #1 should receive a sling to her left upper extremity every shift. Review of nursing progress notes dated 07/29/25, 07/30/25, 08/01/25, and 08/04/25 revealed Resident #1's splint and sling were not in place because staff could not find them. Observation on 08/04/25 at approximately 10:00 A.M. revealed Resident #1 interacting with staff in the hallway. Resident #1 was not wearing a splint or sling during the observation. Observation on 08/04/25 at 4:39 P.M. revealed Resident #1 sitting in a wheelchair in the common area. Resident #1 was not wearing a splint or sling on her left arm. Interview on 08/04/25 at 4:41 P.M. with Registered Nurse (RN) #368 confirmed Resident #1 was not wearing the splint or sling on her left arm as ordered by the physician because RN #368 could not locate them. RN #368 stated she had been looking for them since the previous week and confirmed she documented in Resident #1's chart regarding the missing splint and sling. Interview on 08/04/25 at 4:43 P.M. with Resident #1 revealed her left arm felt more comfortable when she wore the splint and sling. Observation on 08/06/25 at 8:56 A.M. revealed Resident #1 standing in the common area wearing a splint and sling on her left hand and arm. Interview on 08/06/25 at approximately 8:58 A.M. with RN #368 stated staff searched in the basement and were able to find a splint and sling for Resident #1. Interview on 08/06/25 at 9:01 A.M. with Resident #1 revealed her left arm still hurt, but felt more comfortable with the splint and sling. Interview on 08/06/25 at 2:30 P.M. with the Director of Nursing (DON) confirmed she read through all residents' progress notes with the interdisciplinary team during morning meetings, generally Monday through Friday. The DON stated she was off work 07/29/25 and 07/30/25 and would not have reviewed the notes in Resident #1's chart indicating the splint and sling were not available. The DON further stated the rest of the team should have read the notes in her absence. Interview on 08/06/25 at 2:52 P.M. with [NAME] President of Clinical Services (VPCS) #400 confirmed the expectation was staff would request a new sling and splint from the therapy department. VPCS #400 stated she read Resident #1's progress notes Monday morning (08/04/25) and retrieved a new splint and sling for Resident #1 when she arrived at the facility the afternoon of 08/04/25. Interview on 08/12/25 at 12:05 P.M. with Occupational Therapist (OT) #350 revealed she was familiar with Resident #1. OT #350 stated Resident #1 came to the facility with orders for the splint and sling to her left hand and arm. OT #350 stated Resident #1 had slight contractures to her left hand and the splint was to prevent worsening of the contractures. OT #350 stated the sling was due to a fractured collar bone Resident #1 suffered prior to admission. Resident #1 refused to attend a follow-up orthopedic appointment; therefore, the recommendation was to continue use of the sling on Resident #1's left arm.		

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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 observation, medical record review, and staff interview, the facility failed to adequately assess a resident following an unwitnessed fall and failed to ensure adequate supervision to prevent a resident from consuming food not in their diet. This affected two (#56 and #38) of two residents reviewed for accidents. The facility census was 74. Findings include: 1. Review of the medical record for Resident #56 revealed an admission on [DATE] with diagnoses of paranoid schizophrenia, major depressive disorder, and pseudobulbar affect. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #56 was cognitively intact. Further review of the MDS assessment revealed Resident #56 used a walker to ambulate and required supervision for activities of daily living (ADLs). Review of the care plan dated 07/15/25 revealed Resident #56 was at risk for falls and potential injury related to psychoactive drug use, and staff were to minimize the potential risk factors related to falls. Additional review of the care plan revealed Resident #56 used psychotropic medications related to paranoid schizophrenia, major depressive disorder, and anxiety disorder. Resident #56 was to remain free of drug related complications including gait disturbances. Staff were to report any adverse reactions, including unsteady gait or shuffling gate. Observation on 08/12/25 at 10:03 A.M. at the Connections nurses station revealed Resident #56 approximately ten feet from the nurse's station lying on the ground with her walker next to her yelling for help. Licensed Practical Nurse (LPN) #381 was behind the nurse's station at this time. At 10:05 A.M., Housekeeper #376 came out of a resident room stated to Resident #56, Come on get up, and helped Resident #56 off the floor. Housekeeper #376 then went back into room [ROOM NUMBER] without reporting the incident. Interview on 08/12/25 at 10:07 A.M. with LPN #381 revealed she was unaware Resident #56 was on the floor. LPN #381 heard Resident #56 yelling out but stated she was preoccupied with charting. LPN #381 stated she was unsure where the nurse aides were during this time. Further interview with LPN #381 revealed if a resident was on the floor and it was not witnessed the nurse should complete a head-to-toe assessment, neurological checks, call the doctor and resident representative, tell management, and complete a fall packet. LPN #381 confirmed Housekeeper #376 did not report that Resident #56 was on the ground and was only aware due to being told by this surveyor. Review of the progress note for Resident #56 on 08/12/25 at 10:16 A.M. revealed Resident #56 put herself on the floor in the hallway and housekeeping helped Resident #56 up. Interview on 08/12/25 at 10:48 with Housekeeper #376 revealed she did not see Resident #56 fall and came out of the resident room on 08/12/25 due to hearing Resident #56 yelling. Housekeeper #376 confirmed she did not report it to the nurse. Interview on 08/12/25 at 10:57 A.M. with Chief Nursing Officer #401 confirmed the nurse should complete a fall assessment when a resident has an unwitnessed fall. 2. Review of the medical record for Resident #38 revealed an admission date of 12/28/23 with (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnoses of Alzheimer's disease, dementia, oropharyngeal dysphagia, and schizoaffective disorder. Review of the quarterly MDS assessment, dated 07/07/25, revealed Resident #38 had mildly impaired cognition, used a walker and wheelchair for mobility, was able to eat with supervision or touching assistance, and was able to wheel 50 feet with two turns once seated in her wheelchair. Further review revealed Resident #38 was on a texture modified diet. Review of the physician order dated 01/16/25 revealed Resident #38 was on a regular diet with pureed textures and thin liquids. Review of the care plan, updated 06/05/25, revealed Resident #38 displayed behavioral symptoms, including taking food off other resident trays. Interventions included verbal redirection and intervening when Resident #38 displayed inappropriate behavior. Review of a progress note dated 05/16/25 revealed Resident #38 was at the food cart stealing regular texture food off other residents' trays. Resident #38 was educated and redirected. Review of a progress note dated 05/27/25 revealed Resident #38 was eating regular food. Resident #38 was educated twice but refused to give the food back to staff. Review of a progress note dated 06/14/25 revealed Resident #38 was caught eating steak out of the trash. Resident #38 was redirected. Review of a progress note dated 07/04/25 revealed Resident #38 took a hamburger off a discharged resident's food tray. Resident #38 was educated and refused to return the hamburger. Resident #38 consumed the hamburger without issue. Observation on 08/11/25 at approximately 9:05 A.M. revealed [NAME] President of Clinical Services (VPCS) #400 in the nurses station at the medication cart with her back to Resident #38. Further observation revealed Resident #38 opened the tray cart in the hallway and reaching inside, lifting the lid off another resident's tray, and pulling out two pieces of bacon. Resident #38 then turned in her wheelchair and began to wheel away from the area while eating a piece of the bacon. Interview on 08/11/25 at approximately 9:07 A.M. with VPCS #400 confirmed Resident #38 had bacon. Concurrent observation revealed VPCS #400 removed the bacon from Resident #38's hands and provided education. Interview on 08/11/25 at 9:08 A.M. with Certified Nurse Aide (CNA) #404 confirmed Resident #38 regularly took food from other residents' plates. Staff had to monitor Resident #38 closely because of this behavior. Further interview revealed CNA #404 was in the dining room during the observation at approximately 9:05 A.M. when Resident #38 removed bacon from the tray cart. CNA #404 confirmed Resident #38 was on a pureed diet. Further, CNA #404 confirmed the tray Resident #38 removed the bacon from was an untouched tray for a resident who was hospitalized . Interviews on 08/12/25 at 9:51 A.M. with LPN #405 and CNA #371 revealed they were familiar with Resident #38 and her behavior of taking food from other residents' trays. LPN #405 and CNA #371 stated the expectation was staff would monitor Resident #38 and redirect her when needed. Interview on 08/12/25 at 9:56 A.M. with VPCS #400 and Chief Nursing Officer #401 revealed they were unable to provide any additional interventions developed by the facility to prevent Resident #38, who was on a pureed diet, from obtaining and consuming regular texture foods from other residents' trays. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00166789 (1260025).		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, resident interview, physician interview, and policy review, the facility failed to ensure a resident urinary tract infection was timely and appropriately treated; and failed to ensure a urinary catheter was patent and functioning properly. This affected two (#69 and #81) of two residents reviewed for bowel and bladder concerns. The facility identified three residents with urinary tract infections and six residents with urinary catheters. The facility census was 74. Findings include:1. Review of the medical record for Resident #69 revealed an admission date of 03/29/21. Diagnoses included type two diabetes mellitus, depression, schizoaffective disorder, peripheral vascular disease, and hypertension. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #69 had intact cognition. The resident was occasionally incontinent of bowel and bladder. The resident required substantial/maximal assistance of staff for toileting. Review of a physician order dated 07/22/25 revealed an order for a urinalysis with culture if indicated for dysuria. The nurse was to collect the urine and place in the specimen in the laboratory refrigerator and follow up with results in three days. Review of a nurses note dated 07/24/25 at 9:01 A.M. revealed the nurse was unable to collect a urinary specimen as Resident #69 was unable to produce enough specimen. The nurse would continue to try and collect it. Review of Resident #69's nurses notes dated 07/24/25 through 07/29/25 revealed no documentation of further attempts to obtain a urine specimen for the resident. There was no documentation the resident had been monitored for continued and further signs of infection. Review of Resident #69's nurses note dated 07/30/25 at 6:22 P.M. revealed an order was placed for a urinalysis and the resident had possible symptoms (of a urinary tract infection) and a specimen was placed in the refrigerator that was caught via clean catch (a midstream sample collection of urine). Review of a urinalysis laboratory report dated 08/02/25 revealed a urine specimen was collected on 07/30/25 and received by the laboratory on 07/31/25 for Resident #69. Further review of the laboratory report revealed the facility was notified on 08/02/25 of the culture and sensitivity laboratory results showing the resident had greater than 100,000 Klebsiella Pneumonia bacteria. The bacteria was resistant to the antibiotic nitrofurantoin (Macrobid) and susceptible to nine other antibiotics including ciprofloxacin. Review of Resident #69's nurses note dated 08/04/25 at 9:46 A.M. revealed the physician was notified of results. Interview on 08/04/25 at 2:12 P.M., Resident #6 revealed she had signs and symptoms of a urinary tract infection including weakness, burning, and lethargy for a few weeks and had not received any antibiotic. Resident #6 revealed a urine sample had been collected but she had not heard anything back about the results or treatment. Resident #6 revealed the nursing staff never followed up with her regarding her symptoms which continued to increase. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #69's nurses notes from 08/05/25 through 08/06/25 revealed there was no follow up with the physician or resident until after surveyor intervention. Review of a nurses note dated 08/06/26 at 12:33 P.M. revealed the resident was reporting dysuria and lower back pain. The physician was updated with new orders to recheck the urine and start the medication Pyridium (used to treat pain, burning and discomfort of urinary tract infections but does not treat the infection) were given. Interview on 08/07/25 at 4:15 P.M., Registered Nurse (RN) #370 revealed the physician should have been notified when the staff were unable to obtain a urine specimen from 07/24/25 through 07/30/25. RN #370 revealed it should not have taken six days to obtain a urine sample. RN #370 also verified there was no documentation of the resident's signs and symptoms of infection and no documentation the resident had been properly monitored for signs and symptoms of infection and the physician updated of the resident's continued signs and symptoms of a urinary tract infection. Review of a nurses note dated 08/08/25 at 10:07 P.M. revealed the physician wanted Resident #69 started on the antibiotic Macrobid 100 milligrams (mg) twice daily for seven days. Review of the medication administration record (MAR) dated 08/01/25 through 08/31/25 revealed Resident #69 was administered Macrobid 100 mg twice on 08/09/25, and twice 08/10/25, and once on 08/11/25. Interview on 08/11/25 at 2:30 P.M., [NAME] President Clinical Services (VPCS) #400 verified the laboratory report culture and sensitivity results indicated the Klebsiella Pneumonia bacteria was resistant to Macrobid (nitrofurantoin). VPCS #400 verified the physician had ordered the one antibiotic the bacteria was resistant to. VPCS #400 revealed she would notify the physician. Review of Resident #69's nurses note dated 08/11/25 at 3:12 P.M. revealed the physician was notified regarding the urinalysis results and a new order was received to change the antibiotic to Cipro (ciprofloxacin). Review of a physician order dated 08/11/25 at 7:00 P.M. revealed Resident #69 had an order for ciprofloxacin 500 milligrams by mouth two times a day for urinary tract infection for ten days. Interview on 08/12/25 at 2:24 P.M., Physician #410 revealed he was notified of Resident #69's laboratory results and should have followed up to ensure the resident was ordered the right antibiotic. Review of the undated facility policy titled, Laboratory Order Processing, revealed if a laboratory could not be drawn the same day then the physician would be notified for new orders and guidance. The physician would be notified of laboratory results as appropriate with new orders processed at this time. Review of the, Antibiotic Stewardship Policy, last revised 05/2025, revealed the facility would implement an Antibiotic Stewardship Program which would promote appropriate use of antibiotics while optimizing the treatment of infections and to limit antibiotic resistance in the post-acute care setting, while improving treatment efficacy and resident safety, and reducing treatment-related costs. Further policy review revealed the facility would use diagnostic testing to optimize tracking and treatment of infections. 2. Review of the medical records for Resident #81 revealed an admission date of 07/31/25 with (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnoses of unspecified dementia, retention of urine, and diabetes insipidus. Review of the admission care plan dated 08/15/25 revealed Resident #81 had an activities of daily living (ADL) self-care performance deficit related to dementia and schizoaffective disorder. Staff were to assist with toileting and was provide supportive care as needed. Further review of the care plan revealed Resident #81 had an indwelling suprapubic catheter. Resident #81 was to remain free from catheter related trauma by monitoring pain and discomfort, providing catheter care per physician orders, and notifying the physician of any abnormalities. Review of the physician orders for Resident #81 dated 08/01/25 revealed suprapubic catheter #16 French (Fr) to straight drain, and suprapubic catheter care every shift. Observation on 08/05/25 at 2:01 P.M. in Resident #81's bedroom revealed Resident #81 ambulating out of the bathroom behind his bedroom curtain. Resident #81 had his pants off and began urinating on the floor from his penis. Resident #81 had a suprapubic catheter with a leg bag attached to his left leg that was empty. Interview on 08/05/25 at 2:02 P.M. with Resident #81 revealed he reported his catheter not working to the nurse, and the nurse stated there was nothing they could do. Interview on 08/05/25 at 2:04 P.M. with Licensed Practical Nurse (LPN) #383 revealed that was the first time she had taken care of Resident #81 and was told he took care of himself. LPN #383 stated she was unaware the catheter was not functioning and furthermore did not know Resident #81 had a suprapubic catheter. Interview on 08/05/25 at 2:10 P.M. with Assistant Director of Nursing (ADON) #370 revealed the nurse should monitor Resident #81's suprapubic catheter and notify the physician of any abnormal findings. ADON #370 stated Resident #81 pulled on his catheter when taking his pants on and off. Interview on 08/06/25 at 10:05 A.M. with ADON #370 revealed a new suprapubic catheter was placed in Resident #81 on 08/05/25 due to the other catheter not draining properly. Review of the facility policy titled, Foley Catheter Care Policy, dated 01/09/25, revealed the nurse will perform catheter care with soap and water every shift and as needed.		

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed timely notify the physician of abnormal laboratory results. This affected one (#69) of two residents reviewed for bowel and bladder concerns. The facility census was 74. Findings include: Review of the medical record for Resident #69 revealed an admission date of 03/29/21. Diagnoses included type two diabetes mellitus, depression, schizoaffective disorder, peripheral vascular disease, and hypertension. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #69 had intact cognition. Review of Resident #69's physician order dated 07/22/25 revealed an order for a urinalysis with culture if indicated for dysuria. The nurse was to collect the urine and place in the laboratory refrigerator and follow up with result in three days. Review of a nurses note dated 07/24/25 at 9:01 A.M. revealed the nurse was unable to collect a urinary specimen as Resident #69 was unable to produce enough specimen. The nurse would continue to try and collect a specimen. Review of the nurses notes dated 07/24/25 through 07/29/25 revealed no documentation of further attempts to obtain a urine specimen for Resident #69. There was no documentation the physician was notified the urine specimen had not been obtained. Review of a nurses note dated 07/30/25 at 6:22 P.M. noted to place an order for an urinalysis. Resident #69 had possible symptoms (of a urinary tract infection) and a specimen was obtained. Review of Resident #69's urinalysis laboratory report dated 08/02/25 revealed a urine specimen was collected on 07/30/25 and received by the laboratory on 07/31/25. Further review of the laboratory report revealed the facility was notified on 08/02/25 of the culture and sensitivity laboratory results showing the resident had greater than 100,000 Klebsiella Pneumonia bacteria. The bacteria was resistant to the antibiotic nitrofurantoin (Macrobid) and susceptible to nine other antibiotics including ciprofloxacin. Review of the nurses notes dated 08/02/25 and 08/03/25 revealed no documentation the physician was timely notified of the urinalysis results. Review of a nurses note dated 08/04/25 at 9:46 A.M. revealed the physician was notified of results. Interview on 08/07/25 at 3:30 P.M., [NAME] President of Clinical Operations (VPCS) #400 verified the physician was not timely notified of the laboratory urinalysis results. Interview on 08/07/25 at 4:15 P.M., Registered Nurse (RN) #370 revealed the physician should have been notified when the staff were unable to obtain a urine specimen from 07/24/25 through 07/30/25. RN #370 also verified the physician should have been notified on 08/02/25 when the laboratory results had been received. Review of the policy titled, Notification of Change in Condition, updated 06/2025, revealed the nurse would consult with the resident's physician when there was a significant change in the resident's health status including complications. Also, when there was a need to alter treatment significantly including abnormal laboratory results.		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, resident interview, staff interview, and facility policy review, the facility failed to ensure residents received adaptive equipment with meals as ordered. This affected one (#15) of one residents reviewed for adaptive equipment at meals. The facility census was 74. Findings include: Review of the medical record revealed Resident #15 was admitted on [DATE]. Diagnoses included Parkinson's disease with dyskinesia with fluctuations, type two diabetes mellitus, paranoid schizophrenia, essential hypertension, and hypothyroidism. Review of the Minimum Data Set (MDS) assessment, dated 06/28/25, revealed Resident #15 was cognitively intact. Review of the care plan, revised 06/22/25, revealed Resident #15 had a nutritional concern and required adaptive equipment for meals. Interventions included weighted built up utensils, two handled cup, and separate bowl for all meals. Review of the physician order, dated 07/02/25, revealed Resident #15 was ordered a regular diet, regular texture, thin consistency, weighted built up utensils, a two-handled cup with lid, and separate bowls at all meals. Review of the meal ticket, dated for the lunch meal on 08/04/25, revealed Resident #15 was to receive all food in bowls. Interview on 08/04/25 at 11:28 A.M. with Resident #15 revealed meals are to be provided in bowls and last Thursday a meal was not provided in bowls as ordered. Observation on 08/04/25 at 12:38 P.M. of Resident #15's meal tray revealed her meal was provided on a divided plate and not in bowls. Interview on 08/04/25 at 12:39 P.M. with Licensed Practical Nurse (LPN) #383 verified Resident #15's lunch meal was not served in bowls. Review of policy for adaptive devices, revised 09/08/21, verified assistive devices shall be provided to residents who need them.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to maintain complete and accurate resident medical records. This affected one (#20) of three residents reviewed for medical record content. The facility census was 74. Findings Include: Review of the medical record for Resident #20 revealed the resident was admitted on [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting the right side, Parkinson ' s disease, vascular dementia, major depressive disorder, and dysphagia. Review of the Minimum Data Set (MDS) assessment, dated 06/27/25, revealed Resident #20 had unclear speech, was not orientated to time, used wheelchair, required setup assistance for eating, toileting, and personal hygiene, and needed substantial assistance for shower, dressing, and transfers. Review of the care plan, dated 06/09/25, revealed Resident #20 was at possible nutritional risk due to comorbidities and has hemiplegia and hemiparesis to right dominate side related to stroke. Interview 08/06/25 at 8:21 A.M. with Licensed Practical Nurse (LPN) #335 revealed Resident #20 had an incident about a month ago where the Heimlich maneuver (a first-aid procedure used to dislodge an object blocking a person's airway) was performed successfully to dislodge a tater tot that Resident #20 was choking on. LPN #335 stated an assessment was done including vital signs taken and Resident #20 ' s diet was switched to mechanical soft until speech therapy could evaluate the resident. Review of the medical records for Resident #20 revealed no documentation of the choking incident, assessment after the incident, or Resident #20 having an order for a mechanical soft diet. Review of a policy titled, Documentation Guidelines, dated December 2021, revealed the following information should be recorded in the resident ' s medical record: documenting an observation or interaction with the resident or person relevant to the care and services for the resident. This could be defined as an episodic note and to include the date/time of the observation/interaction, relevant information from the interaction, physician orders or communication as a result, and signature.		

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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 medical record review, staff and interview, physician interview, and policy review, the facility failed to ensure antibiotics were appropriately prescribed for urinary tract infections. This affected three (#69, #5, and #24) of four residents reviewed for antibiotic stewardship. The facility identified seven residents as receiving antibiotics. The facility census was 74. Findings include: 1. Review of the medical record for Resident #69 revealed an admission date of 03/29/21. Diagnoses included type two diabetes mellitus, depression, schizoaffective disorder, peripheral vascular disease, and hypertension. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #69 had intact cognition. The resident was occasionally incontinent of bowel and bladder. The resident required substantial/maximal assistance of staff for toileting. Review of Resident #69's urinalysis laboratory report dated 08/02/25 revealed a urine specimen was collected on 07/30/25 and received by the laboratory on 07/31/25. Further review of the laboratory report revealed the facility was notified on 08/02/25 of the culture and sensitivity laboratory results showing the resident had greater than 100,000 Klebsiella Pneumonia bacteria. The bacteria was resistant to the antibiotic nitrofurantoin (Macrobid) and susceptible to nine other antibiotics including ciprofloxacin (Cipro). Review of Resident #69's nurses note dated 08/04/25 at 9:46 A.M. revealed the physician was notified of results. Review of Resident #69's physician order dated 08/09/25 at 2:56 P.M. revealed the physician ordered Macrobid (nitrofurantoin) 100 milligrams (mg) by mouth two times a day for seven days. Review of Resident #69's medication administration record (MAR) dated 08/01/25 through 08/31/25 revealed the resident was administered Macrobid 100 mg twice on 08/09/25, twice 08/10/25, and once on 08/11/25. Interview on 08/11/25 at 2:30 P.M., with [NAME] President Clinical Services (VPCS) #400 verified the laboratory report culture and sensitivity results for Resident #69 indicated the Klebsiella Pneumonia bacteria was resistant to Macrobid (nitrofurantoin) which the physician ordered for the resident. VPCS #400 revealed she would notify the physician. Review of Resident #69's nurses note dated 08/11/25 at 3:12 P.M. revealed the physician was notified regarding the urinalysis results and a new order was received to change the antibiotic to Cipro. Review of Resident #69's physician order dated 08/11/25 at 7:00 P.M. revealed the resident had an order for ciprofloxacin 500 mg by mouth two times a day for urinary tract infection for ten days. Interview on 08/12/25 at 2:24 P.M., with Physician #410 revealed he was notified of Resident #69's laboratory results and should have followed up to ensure the resident was ordered the right antibiotic. 2. Review of the medical record for Resident #5 revealed an admission date of 06/26/23 with diagnoses of neuromuscular dysfunction of the bladder, dementia, Crohn's disease, and mixed (continued on next page)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incontinence. Review of the quarterly MDS assessment, dated 06/02/25, revealed Resident #5 had impaired cognition, was dependent for toileting, and had an indwelling catheter. Review of the significant change comprehensive MDS assessment, dated 07/21/25, revealed Resident #5's cognition could not be assessed and she had an indwelling catheter. Review of a progress note dated 06/06/25 revealed Resident #5 was seen by the physician after pulling out an intravenous (IV) line being used to provide fluids for dehydration. The physician ordered Levaquin (an antibiotic) 500 mg daily for seven days. Review of a physician order dated 06/06/25 revealed Resident #5 received Levaquin 500 mg once daily for infection for seven days. Review of the document titled, McGeer Criteria for Infection Surveillance Checklist, revealed Resident #5 was identified with an infection on 06/07/25. Resident #5 was evaluated for a urinary tract infection (UTI). No signs or symptoms of a UTI were documented. The bottom of the document had a check-marked box indicating UTI criteria was not met. Interview on 08/12/25 at approximately 12:33 P.M. with VPCS #400 confirmed Resident #5's medical record, and the facility's infection surveillance checklist, included no indication for initiating antibiotics on 06/06/25. VPCS #400 confirmed no urinalysis was obtained and no culture and sensitivity was obtained for Resident #5 on or around 06/06/25. 3. Review of the medical record for Resident #24 revealed an admission date of 07/09/25 with diagnoses of benign prostatic hyperplasia, hematuria, obstructive and reflux uropathy, and retention of urine. Review of the comprehensive admission MDS assessment, dated 07/16/25, revealed Resident #24 had impaired cognition, required substantial/maximal assistance for toileting, and had an indwelling catheter. Review of the urine collection laboratory testing, collected 07/21/25, and reported 07/25/25, revealed Resident #24's urine showed probable contamination because greater than or equal to three organisms were isolated. Review of the physician order dated 07/27/25 revealed Resident #24 received Macrobid 100 mg twice daily for UTI until 08/06/25. Review of the document titled, McGeer Criteria for Infection Surveillance Checklist, revealed Resident #24 was identified with an infection on 07/27/25. Resident #24 was evaluated for a UTI. A handwritten note documented Resident #24 had discolored urine with odor and visible mucous. The bottom of the document had a check-marked box indicating UTI criteria was not met. Interview on 08/12/25 at approximately 12:33 P.M. with VPCS #400 confirmed Resident #24's urinalysis was inconclusive, and the physician provided no order to collect a new sample of urine for re-testing. VPCS #400 stated the facility staff notified the physician when the use of an antibiotic did not meet the criteria; however, the physician did not order another urine sample to be tested for (continued on next page)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #24 before prescribing an antibiotic. Review of the facility policy titled, Antibiotic Stewardship Policy, updated 05/2025, revealed it was the policy of the facility to promote appropriate use of antibiotics by evaluating and communicating clinical signs and symptoms when a resident was first suspected of having an infection and the use of diagnostic testing to optimize tracking and treatment of infections. The facility would implement an Antibiotic Stewardship Program which would promote appropriate use of antibiotics while optimizing the treatment of infections and to limit antibiotic resistance in the post-acute care setting, while improving treatment efficacy and resident safety, and reducing treatment-related costs. Further policy review revealed the facility would use diagnostic testing to optimize tracking and treatment of infections.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on medical record review, staff interview, and policy review, the facility failed to ensure residents received education prior to accepting or refusing a pneumococcal vaccination. This affected two (#3 and #38) of five residents reviewed for pneumococcal vaccination. The census was 74. Findings include: 1. Review of the medical record for Resident #3 revealed an admission date of 08/28/13 with diagnoses of chronic respiratory failure, heart disease, hyperlipidemia, and dementia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/03/25, revealed Resident #3 had intact cognition. Review of the immunization history for Resident #3 revealed she received the pneumococcal conjugate vaccine (PCV) 20 on 12/15/23. 2. Review of the medical record for Resident #38 revealed an admission date of 12/28/23 with diagnoses of Alzheimer's disease, dementia, schizoaffective disorder, chronic obstructive pulmonary disease, and hypertension. Review of the quarterly MDS assessment, dated 07/07/25, revealed Resident #38 had mildly impaired cognition. Review of the immunization history for Resident #38 revealed she refused the pneumococcal vaccine on 04/15/24. Interview on 08/12/25 at approximately 12:30 P.M. with [NAME] President of Clinical Services (VPCS) #400 confirmed the facility could provide no evidence Resident #3 received education regarding the risks and benefits of receiving the pneumococcal vaccine prior to receiving it on 12/15/23. Further, VPCS #400 confirmed the facility could provide no evidence Resident #38 received education regarding the risks and benefits of receiving the pneumococcal vaccine prior to declining it on 04/15/24. Review of the policy titled, Pneumococcal Vaccine Policy, dated 09/25/24, revealed the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine prior to receiving the vaccine.		