STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365774	A. Building B. Wing	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medina Bsd Opco LLC	550 Miner Dr Medina, OH 44256

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 0690 Level of Harm - Immediate jeopardy to resident health or safety 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 record review, observations, hospital record review, interviews, and policy review, the facility failed to ensure safe, clinically indicated, and competent Foley catheter insertion and follow^up monitoring for Resident #64 and failed to follow physician orders for indwelling catheter care for Resident #37. This resulted in Immediate Jeopardy and serious life-threatening harm, negative health outcomes, and/or death for one resident (#64) when Licensed Practical Nurse (LPN) #800 performed a non^ordered Foley catheter change on [DATE] while Resident #64 was visibly moving, resisting, and verbalizing pain, without clinical assessment, supervisory involvement, or medical provider notification. There was no documented evidence of assessment of insertion difficulty, trauma, or need for escalation. Later that evening, the resident developed severe pain (10/10) and hematuria, but staff did not notify the physician or perform further assessment. By 1:00 A.M. on [DATE], Resident #64 was slow to arouse, hypotensive, tachycardic, and the catheter bag was filled with dark red blood. The resident was emergently hospitalized , and imaging confirmed the Foley catheter had been malpositioned in the urethra, causing bladder distention, urethral and bladder trauma, and subsequent urosepsis. Resident #64 died on [DATE]. In addition, the facility failed to ensure adherence to physician orders and proper monitoring for a second resident's (#37) indwelling catheter, placing the resident at risk for more than minimal harm that was not Immediate Jeopardy, when monthly catheter changes and shift^based intake/output monitoring were not completed as ordered. This deficient practice affected two (#64 and #37) of four residents reviewed for catheter care. The facility census was 52.On [DATE] at 2:13 P.M., the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and Regional [NAME] President of Nursing (RVPN) #830 were informed that Immediate Jeopardy began on [DATE] due to the facility's failure to provide competent catheter insertion, timely assessment, and appropriate escalation of a significant change in condition, resulting in urosepsis and the death of Resident #64. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: - On [DATE], the facility initiated an internal investigation led by the LNHA, Former DON #915, Assistant Director of Nursing (ADON) #649, and RVPN #830. Immediate corrective measures were put in place to ensure resident safety related to Foley catheter insertion.- Staff present during the catheter^related events between [DATE] and [DATE] were interviewed by ADON #649 on [DATE].- ADON #649 completed a facility^wide review of all residents with indwelling catheters on [DATE] between 10:00 A.M. and 11:00 A.M., identifying no additional concerns. There are three like residents as of [DATE].- Communication with Long^Term Care Ombudsman #805 began on [DATE] regarding the plan of care, with findings deemed satisfactory by [DATE].- All nursing staff completed competency evaluations for male and female catheterization between [DATE] and [DATE]. Competencies were completed by Former DON #915.- An ad hoc Quality Assessment and Performance Improvement (QAPI) meeting was held on [DATE] to review findings and approve corrective actions.- On [DATE], RVPN #831 conducted a full audit of all residents with Foley catheters (#16, #37, #68), including review of documentation and sepsis indicators; no additional issues were found.- Unit Manager Registered Nurse (RN) #711 completed (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

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	physical assessments of all residents with Foley catheters on [DATE], verifying placement and identifying no concerns.- A Root Cause Analysis (RCA) was completed on [DATE] at 3:30 P.M. by the DON, LNHA, RVPN #830, and Medical Director #833.- A second ad hoc QAPI meeting was held on [DATE] at 7:15 P.M. with full interdisciplinary attendance to review the RCA and the updated abatement plan. The plan was approved, and the committee assumed responsibility for ongoing monitoring. The QAPI committee accepted the plan and will continue oversight monitoring.- One hundred percent (100%) of licensed nursing staff (14/14 LPNs and 6/6 RNs) completed refreshed competencies on male and female catheterization during a skills fair from [DATE] to [DATE]. The skills fair was put on by managers/leaders: Human Resource (HR) Director #688, Certified Nursing Assistant (CNA) #712, Unit Manager RN#711, ADON #649, Respiratory Therapist (RT) #843 and the DON.- All nursing staff received education on early recognition of sepsis symptoms from [DATE] to [DATE] by LPN #621, Unit Manager RN #711, and the DON. This education was prepared by RVPN #831.- Orientation procedures were updated to require catheterization and sepsis education for all newly hired nurses before independent practice.- The DON and/or designee-initiated audits of all residents with Foley catheters daily for one week, then three times weekly for four weeks, then monthly.- The DON and/or designee implemented weekly postˆtests (five nurses per week for four weeks) on early recognition of sepsis.- The QAPI committee will review ongoing data monthly and as needed.- All catheterˆrelated irregularities must be immediately reported to the DON, and all related incidents will undergo a DONˆled investigation with RVPN #830 review within 24-48 hours.Although the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at a Severity Level 2 (no actual harm with the 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. Closed record review revealed Resident #64 was admitted on [DATE] with diagnoses including urinary retention and neuromuscular dysfunction of the bladder. The care plan dated [DATE] identified an indwelling Foley catheter for neurogenic bladder with interventions to keep the tubing secured, monitor for pain or discomfort, and report signs of urinary tract infection (UTI) to the physician.The quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 6/15 indicating severe cognitive impairment. Resident #64 required assistance with toileting and personal hygiene, but he remained independent with bed mobility and wheelchair mobility and could ambulate 50 feet with supervision.Review of the [DATE] physician orders revealed Resident #64 had orders dated [DATE] for a Foley catheter 16 French (fr) with 30 cubic centimeter (cc) balloon, change monthly on the 16th day, day shift starting on the 16th and ending on the 16th every month for neurogenic bladder; an order dated [DATE] to use a Foley leg bag when the resident is up out of bed for safety issue; an order dated [DATE] to drain Foley catheter bag every shift and as needed (PRN) four times a day for catheter care; an order dated [DATE], may irrigate Foley catheter with 30 milliliters (ml) of sterile water PRN for obstruction or increased sediment; and an order dated [DATE] for Tramadol HCL oral tablet 25 milligrams (mg), give one tablet by mouth every eight hours PRN for pain. (There was no order to change the Foley catheter PRN). A physician progress note dated [DATE] indicated the resident was stable, with no recent emergency visits, and his Foley was draining clear yellow urine. No abnormalities were identified.Review of the [DATE] Medication Administration Record (MAR) and Treatment Administration Record (TAR) showed the Foley catheter was last changed on [DATE] by LPN #811 and irrigated on [DATE]. Pain levels were consistently zero throughout the month except during five shifts with pain levels ranging 2-5, and a single elevated reading of 10/10 pain on [DATE] at 8:00 P.M. following the catheter replacement. There was no documented physician notification of this new and severe pain and hematuria.No nursing progress notes were documented for [DATE], [DATE], or [DATE]. A nurse's note from [DATE] at 10:31 A.M. (LPN #811) documented stable vital signs, no pain, and clear yellow urine.A late entry dated [DATE] at 7:06 P.M. (LPN #800) documented that on [DATE] at 1:03 P.M., the resident's wife expressed (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	concern that he was still using the large (bedside) drainage bag instead of the ordered leg bag. The nurse changed the bag, noted clear yellow urine, and documented no pain. A second late entry dated [DATE] at 7:11 P.M. (LPN #800) documented that at 3:30 P.M. on [DATE], the granddaughter reported catheter problems. The nurse took the resident to his room and removed and replaced the Foley catheter. The documentation noted the resident attempted to sit up and move during insertion. The LPN inserted a 16 French catheter and inflated the balloon with 10 cc of saline. There was no order for catheter replacement, no documentation of an assessment of difficulty, and no evidence the physician was notified. The note states the resident had no complaints once the Foley was placed, though this conflicts with multiple eyewitness statements. There was no documented evidence to explain why the catheter was changed when there was no order to change it and no evidence to determine if the catheter was obstructed, as it was not flushed per the PRN irrigation orders.Review of the nurse's note dated [DATE] at 8:30 P.M. revealed LPN #619 documented small hematuria, catheter bag change, and administration of PRN Tramadol for generalized pain, rated earlier at 10/10. No provider was notified of pain, hematuria, or the sudden change in condition.Review of the MAR for Resident #64 revealed LPN #619 administered the Tramadol on [DATE] at 8:00 P.M. for pain rated a 10 out of 10. Additional review of the MAR for [DATE] revealed Resident #64's pain level pain was monitored every shift (with the exception of one shift which the assessment was left blank). Resident #64 had a zero-pain level documented on 79 of the 84 shifts. The remaining five shifts revealed a pain level ranging from two to five with the exception of [DATE] at 8:00 P.M. when Resident #64's pain level was 10 out of 10. On [DATE] Resident #64 had a pain level of five documented. The pain levels were zero from [DATE] until [DATE] at 8:00 P.M. There was no documented evidence that the physician was notified of the new onset of pain and hematuria.Review of the nurse's notes dated [DATE] authored by LPN #619, included at 1:00 A.M. on [DATE], a CNA alerted LPN #619 that the resident did not appear well. Assessment revealed the resident was slow to arouse, incontinent of stool, breathing shallowly, and the Foley drainage bag was full of dark red blood. Vital signs (concerning for shock) blood pressure 91/59, pulse 132, respirations 26. Emergency transfer was ordered. Hospital records for [DATE] revealed a Computed Tomography (CT) scan showing the Foley catheter was malpositioned in the urethra, causing bladder distention, wall thickening, and gas within the bladder. A urology consult documented visible discomfort and confirmed gross hematuria and malpositioning after the Foley change at the nursing home.Hospital admission records described septic shock due to gramˆnegative bacteremia, disseminated intravascular coagulation, acute kidney injury, and progressive multiˆorgan deterioration. Despite intensive care, the resident became unresponsive and was pronounced dead on [DATE] at 1:24 P.M. The death certificate listed urosepsis as the immediate cause of death. Review of the staff file for LPN #800 revealed she was later terminated ([DATE]) for failure to respond to a resident change in condition and multiple prior disciplinary actions. This pattern indicated ongoing performance issues relevant to clinical judgment and resident safety.A phone interview with Resident #64's widow on [DATE] at 2:28 P.M. provided consistent and credible account of the resident yelling stop, stop, I can't stand it, during the catheter insertion, repeated attempts by the LPN to force passage of the Foley, and statements by the aide indicating difficulty passing the catheter. She stated no urine had drained after the procedure and that he continued to complain of pain while transporting him to the dining room.Review of the Daily Timecards for [DATE] revealed LPN #619 and RN #616 were the only two nursing staff employees remaining employed at the facility that worked [DATE]. RN #616 was not scheduled to work with Resident #64. Interview with LPN #619 on [DATE] at 4:44 P.M. confirmed that LPN #800 told her the catheter had been changed because the resident was complaining about it and tugging on it, but the nurse did not report any complications during shift report, and no escalation to a provider occurred.Interview on [DATE] at 11:40 A.M. with the DON revealed he did not start working at the facility until [DATE]. He was not working when Resident #64 resided at the facility, so he would not know anything about what happened during that time. Interviews with the LNHA and ADON #649 on (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] from 12:25 P.M. to 12:36 P.M. confirmed that no investigation was initiated at the time of the incident, despite Resident #64 developing catastrophic complications less than 24 hours after the catheter insertion. During interviews on [DATE], the LNHA and ADON #649 stated that no investigation had been completed at the time of the incident in [DATE], and no statements, interviews, or documentation existed or were provided regarding the catheter related event. However, when the surveyor returned to the facility on [DATE], the LNHA provided what was described as a completed investigation, including handwritten statements and phone interviews from former staff. These materials were not available or referenced on [DATE] when the LNHA and ADON #649 reported that no investigation had ever been performed.Review of the Staff Education Packets for [DATE] and [DATE], provided to the surveyor upon request on [DATE], identified by the LNHA as the Staff Monthly Education revealed no information on Foley catheter insertion, education, or care. Phone interview on [DATE] at 9:32 A.M. with Ombudsman #805 revealed that the facility told her in [DATE] that an investigation and competency reviews would occur, but documentation provided to surveyors on [DATE] and interviews completed on [DATE] with LNHA and ADON #649 revealed no evidence that such an investigation or immediate education was completed at the time of the incident.Staff education packets for June and [DATE] provided by the LNHA contained no catheterˆrelated training, despite assurances made to the Ombudsman.Collectively, the evidence shows the facility failed to:- ensure catheter replacement was clinically justified;- perform a competent, safe catheter insertion;- recognize resident distress and early signs of trauma;- assess and monitor for complications;- notify the physician of pain, bleeding, and change in condition;- initiate timely emergency response; and- conduct a required investigation.A phone interview with CNA #842 on [DATE] confirmed she was in the room during the catheter change and directly observed the resident moving, lifting his legs, attempting to squirm away, and verbalizing pain (it hurts down there). She stated the nurse requested a second catheter after the first attempt was no longer sterile and confirmed she saw no urine output after placement.The facility provided a handwritten statement on [DATE] from CNA #841 (not present during the Foley catheter change). The handwritten statement was signed and dated [DATE] (no time). The statement revealed on Saturday [DATE] (no time) CNA #899 and I tried to changed Resident #64's Foley (standard) bag to his leg bag when we realized his penis was bleeding at the tip. There was no blood in his urine; it was just a little darkerˆthan-usual. We went and got the nurse (nurse not specified); she came in and got the bleeding to stop and had me get a new leg bag. (This contradicts the late entry nurse's note dated [DATE] at 7:06 P.M. (LPN #800) documented that on [DATE] at 1:03 P.M., the resident's wife expressed concern that he was still using the large (bedside) drainage bag instead of the ordered leg bag. The nurse changed the bag, noted clear yellow urine, and documented no pain).Record review provided by the facility on [DATE] at approximately 8:30 A.M. of the handwritten interviews with staff regarding Resident #64 revealed a handwritten statement dated [DATE] signed by former employee LPN #800 revealed Resident #64 stated he was having issues with his catheter. He had a large (standard) Foley bag on when she went to assess him. She changed the Foley bag over to a leg bag in his bathroom. His Aide (CNA #841) was in the room when it was changed. Resident #64 had no issues after this; around 3:30 P.M., Resident #64's granddaughter came to me and asked if I was his nurse, and I stated, yes. She said he was still having issues with his catheter. She stated she took Resident #64 into his room with (CNA #842) and changed his entire catheter. I met no resistance. Resident #64 wanted to get up while having the Foley catheter placed and yelled out for his wife. Asked if he had pain, he said no. The Foley catheter was placed at that point. The resident's wife came into the room after the Foley catheter was already placed. He had scant amount of yellow urine come out once the Foley was placed. Resident #64 had no complaints once up in the chair. Resident #64 was not held down at any point, I placed my hand on his shoulder for comfort, not to hold or push him down. An additional statement dated [DATE] and signed by former employee CNA #840, which included around 8:00 P.M. she changed Resident #64's leg bag to his Foley (standard) bag and informed nurse about a small amount of blood. Resident #64 (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	seemed to be his happy go lucky self. An additional statement dated [DATE] completed by former employee CNA #841, revealed on Saturday [DATE] (untimed) (staff) and I tried to change (Resident #64's) Foley bag to his leg bag then we realized that his penis was bleeding at the tip. There was no blood in his urine, it was just a little darker than usual. We went and got the nurse to look at it. She came in and got the bleeding to stop and had me get a new leg bag; she put on the leg bag. The bag was up high enough so he could not pull at the bag. Review of the written statements revealed there was no statement from CNA #842 who was documented to be in the room with Resident #64 on [DATE] during the catheter change.Phone interview on [DATE] at 12:12 P.M. with former employee CNA #842 revealed she remembered Resident #64 and confirmed she was in his room on [DATE] while LPN #800 changed his indwelling catheter. CNA #842 revealed, (LPN #800) put the catheter in. I can't remember anyone else in the room except for his wife; she was in and out a couple of times. When she was trying to put the catheter in, the resident did move around in bed, lifted his legs, and tried to squirm away from her. I did have to go get a new catheter, I don't know why, I think because that one was not sterile anymore, he did seem uncomfortable, it did seem a little difficult, he did say when she was putting it in it was sore and hurt. I did not see any urine in the bag or tubing when she was done.Phone interview on [DATE] at 3:48 P.M. with [NAME] Hospital Infectious Disease Medical Assistant #820 revealed yes, you can become septic from trauma due to catheterization. Every patient is different, some people become septic fast and develop sepsis within a few hours, they can really turn fast, that is why symptoms must be treated seriously. Interview on [DATE] at 11:00 A.M. with the LNHA confirmed there was no written statement from CNA #842 in the file provided for the investigation of [DATE].Attempts to interview Former Employees (CNA #841 and LPN #800) were unsuccessful because calls were not returned. 2. Record review revealed Resident #37 was admitted on [DATE] with diagnoses including endˆstage renal disease and neuromuscular dysfunction of the bladder. The care plan dated [DATE] identified the resident had an indwelling catheter for obstructive uropathy, with interventions requiring monitoring and documentation of intake and output per facility policy.Review of physician orders showed an order dated [DATE] for Foley catheter output to be monitored every shift, and an order dated [DATE] directing the Foley catheter to be changed every 28 days at bedtime and PRN for neuromuscular bladder dysfunction.Review of the MAR for Resident #37 revealed the resident received Ciprofloxacin (antibiotic) for UTIs from [DATE] through [DATE] and again beginning [DATE] for seven days, indicating repeated infectious complications potentially related to catheter management. Review of the quarterly MDS 3.0 assessment dated [DATE] documented that Resident #37 was cognitively intact, dependent on staff for toileting hygiene, and required moderate assistance with personal hygiene. He had an indwelling Foley catheter in place.On [DATE] at 4:07 P.M., nursing documentation showed the resident was sent from dialysis to the emergency department for evaluation and treatment.Hospital records, including the History and Physical dated [DATE] completed by Physician #833, indicated the resident's initial urinalysis at dialysis was positive, but a repeat culture obtained after catheter replacement revealed no infection, confirming the prior infection was associated with the old catheter. The final diagnosis included hypotension and UTI due to an indwelling catheter.Observation and interview on [DATE] at 11:58 A.M. revealed Resident #37 was up in his electric chair. The indwelling catheter bag was attached under the chair. Resident #37 revealed he used to wear a leg bag prior to coming to the facility, but since he had been at the facility, they never gave him one to use. Resident #37 revealed his concern with the indwelling catheter was they were not changing it like his urologist ordered. He said it needed to be changed every 28 days, and he had several UTIs and ended up in the hospital. Interview on [DATE] between 12:02 P.M. and 3:57 P.M. with LPN #600 revealed Resident #37 had his catheter changed last on [DATE] and revealed residents who have a Foley catheter would not receive a leg bag unless they asked for one. During an interview on [DATE] at 2:00 P.M., Certified Nurse Practitioner (CNP) #845 confirmed he was the resident's provider and stated clearly that Resident #37's catheter should be changed monthly at minimum and PRN. After reviewing the chart, he verbally instructed nursing staff (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to ensure the monthly catheter change order was active and implemented. Record review and interview with the DON on [DATE] at 8:54 A.M. confirmed that although the physician wrote an order on [DATE] for catheter changes every 28 days and PRN, the order was incorrectly entered into the electronic medical record (EMR). It was set to recur nightly instead of every 28 days, resulting in nurses frequently electronically signing (nearly every day) the task was completed without any corresponding physical catheter change. The DON confirmed that catheter changes were not being performed monthly as ordered.On [DATE] at 9:53 A.M., the DON also confirmed nurses were not consistently monitoring urine output every shift as required by the [DATE] order, and that documentation did not accurately reflect actual care provided. Review of TARs from [DATE] through [DATE] with the DON confirmed catheter changes occurred on only [DATE], [DATE], and again at the hospital on [DATE]. No catheter changes occurred in January, March, or [DATE] despite ongoing orders.Review of the facility policy titled, Catheter Care, dated [DATE], revealed it is the policy of this facility to ensure the residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. This deficiency represents non-compliance investigated under Complaint Numbers 2626312 and 2574149.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, review of manufacturer guidelines, and review of facility policies, the facility failed to ensure medications were administered in accordance with physician orders and accepted standards of practice resulting in a significant medication error for Resident #70. Actual Harm occurred on 11/14/25 when Licensed Practical Nurse (LPN) #800 failed to perform the physicianˆordered preˆmeal blood glucose check and failed to administer the prescribed Lispro insulin prior to the lunch meal. As a direct result of this deviation from physician orders, facility policy, and manufacturer standards, Resident #70 developed severe hyperglycemia with a critically elevated blood glucose of 384ˆmilligrams per deciliter (mg/dL), accompanied by lethargy, hypotension with blood pressure measuring 78/55 millimeters of mercury (mmHG), reduced responsiveness, and clinical decline necessitating transfer to the emergency department for urgent medical evaluation and treatment. This affected one (#70) out of four residents reviewed for medication administration. The facility census was 52.Findings include:Record review revealed Resident #70 was admitted on [DATE] and with diagnoses including diabetes mellitus, anxiety, and major depressive disorder. The resident resided on the 300 Hall.Review of physician orders for November 2025 showed the resident was to have blood sugar checks before meals and to receive Lispro 100 units/mL, four units subcutaneously before meals.The mealtimes posted for the 300 Hall showed lunch was served at 11:15ˆA.M.; however, record review revealed the resident's blood sugar was not checked until 12:33ˆP.M., more than an hour after lunch service. The blood glucose at that time was 384ˆmg/dL. The Director of Nursing (DON) confirmed this timing during review.Review of the electronic medical record (EMR) revealed Resident #70's blood sugar was not checked until 12:33 P.M., more than one hour after lunch was served. The blood glucose level at that time was 384 mg/dL. The DON verified this timing during the record review.Review of the November 2025 medication administration record (MAR) corroborated that the elevated blood glucose reading documented at lunch time (12:33ˆP.M.) indicated insulin was not administered prior to the meal as ordered.Review of the progress note dated 11/14/25 at 1:15 P.M. revealed LPN #800 was notified by Resident #70's family member that he was lethargic and not eating his lunch. His blood pressure was 78/55 mmHG (hypotension) with a pulse of 80. The resident responded only to name. LPN #800 contacted the nurse practitioner and was directed to send the resident to the emergency department.Review of the emergency department Discharge summary dated [DATE] confirmed Resident #70 presented with lethargy and decreased intake; blood glucose remained elevated at 271ˆmg/dL, above the normal range (74-99ˆmg/dL). Family expressed concern that insulin had not been administered timely.Interview on 05/04/26 at 7:58 A.M. with the DON confirmed Resident #70's blood sugar was not checked before lunch, and that LPN #800 was responsible for administering insulin prior to meals.Interview on 05/04/26 at 3:23 P.M. with the Administrator revealed no investigation was conducted related to the medication error involving Resident #70's insulin. Interview on 05/05/26 at 8:01 A.M. with the DON reported that on 11/14/25, the family could not locate LPN #800; she was found in her vehicle on a lunch break and was later terminated. Attempts to interview her were unsuccessful.Review of the Lispro prescribing information (Lilly Insulin Lispro Injection Uˆ100, April 2026) showed the medication is to be administered within 15 minutes before or immediately after meals to manage postˆmeal blood sugar spikes.Review of the facility policy titled Medication Administration, dated 04/09/25, indicated that medication will be administered by legally authorized and trained persons in accordance with State, Local and Federal laws and consistent with accepted standards of practice.This deficient practice represents non-compliance investigated under Complaint Number 2626312.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility policy, the facility failed to ensure staff followed required Enhanced Barrier Precautions (EBP) while providing care for two residents (#36 and #5) of two residents observed for infection control. This failure to follow EBP has the potential to expose the residents and others to infection risk and had the potential to affect an additional 13 residents (#2, #7, #9, #10, #16, #27, #32, #47, #37, #47, #48, #49, #53 and #68) identified by the facility who also required EBP. The facility census was 52.Findings include: 1. Record review for Resident #36 revealed an admission date of 04/01/22 with diagnoses including osteomyelitis of the right femur, methicillin resistant staphylococcus aureus (MRSA) infection, resistant to unspecified antibiotic, and infection of amputation stump. Review of the Minimum Data Set (MDS) assessment dated [DATE] showed intact shortˆterm memory, frequent incontinence, and need for partial/moderate assistance with toileting hygiene. Care plan dated 04/23/26 indicated Resident #36 required EBP due to a central line and wound care. Interventions included maintaining personal protective equipment (PPE) and supplies outside the room, using gloves and gowns during highˆcontact care, and discarding PPE appropriately.Review of the physician order for Resident #36 with a start date of 04/23/24 revealed an order for EBP related to Peripherally Inserted Central Catheter (PICC) line and wound care every shift for preventative measures. An order for Resident #36 dated 04/24/26 revealed Saline-Administer-Saline (SAS) flush central line right chest (a technique for flushing IV catheters to maintain patency and prevent medication interaction). Administer normal saline five milliliters (ml) IV to port. Infuse antibiotics as ordered. Administer normal saline five ml IV to port every shift for IV antibiotics related to acute osteomyelitis and right femur MRSA infection. Review of the physician order dated 04/27/26 at 9:45 A.M. revealed an order for Vancomycin HCL IV solution 750 milligrams (mg) 15 ml use one dose IV one time only for antibiotic treatment.On 04/27/26 at 11:03 A.M., observation revealed the resident receiving IV medications with no EBP signage displayed and no gowns available. CNA #721 entered to provide incontinence care without donning an isolation gown, despite the resident having a right leg stump dressing in place. At 11:18 A.M., the Director of Nursing (DON) entered to assist with repositioning while not wearing an isolation gown and exited the room without performing hand hygiene. CNA #721 stated she did not wear gowns during personal care unless the resident had an openˆair wound, catheter, or C. difficile.During an interview on 04/27/26 at 11:43 A.M., Licensed Practical Nurse (LPN) #717 confirmed Resident #36 had not been on EBP and that she had just placed the signage and PPE at the door. The posted policy required gowns and gloves during dressing, bathing, transferring, toileting, device care (including central lines), and wound care. At 12:08 P.M., the DON stated staff did not need gowns for repositioning.2. Record review revealed admission on [DATE] with diagnoses including chronic systolic heart failure, acute kidney failure, and weakness. MDS dated [DATE] showed dependency for toileting and transfers, and three Stage II pressure ulcers (partial thickness loss of dermis presenting as a shallow open ulcer with a red, pink wound bed, without slough, may also present as an intact or open/ruptured serum filled blister) present on admission.Review of the care plan dated 04/09/26 revealed Resident #5 had skin breakdown/open area/pressure ulcer to bilateral buttocks related to limited mobility and noncompliance with intervention for prevention, was present upon admission. Interventions included completing the treatment as ordered per physician. Observation on 04/29/26 at 11:11 A.M. of wound care for Resident #5 provided LPN #619 and Registered Nurse (RN) #648 revealed both nurses donned an isolation gown and gloves. After wound care was initiated for Resident #5, LPN #619 requested RN #648 to gather additional supplies. RN #648 exited the room with the isolation gown and gloves on. Observation revealed RN #648 walked up the hall with the gown and gloves before being out of sight. At 11:27 A.M., RN #648 returned to Resident #5's room with the supplies and donned a new gown. RN #648 confirmed she disposed of the gloves and gown in the trash can of the treatment cart located in (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the hall. Interview on 04/29/26 at 11:47 A.M., the Assistant Director of Nursing (ADON)/Wound Care Nurse #649 stated staff should remove PPE before leaving a resident's room, consistent with facility policy.Facility EBP policy dated 09/09/25 defined EBP as targeted gown and glove use during highˆcontact care and required PPE availability outside rooms and appropriate disposal inside rooms. Hand hygiene policy dated 11/06/25 required staff to perform hand hygiene before donning and after removing gloves.Hand Hygiene policy dated 11/06/25 revealed all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. The use of gloves do not replace hand hygiene. If your tasks require gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.

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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 record review, observation, interview, and facility policy review, the facility failed to ensure that Resident #36, who required staff assistance with toileting hygiene, received timely incontinence care. This affected one resident (#36) of eight residents reviewed for activities of daily living (ADL) care. The facility census was 52.Findings include: Record review for Resident #36 revealed an admission date of 04/01/22. Diagnoses included congestive heart failure (CHF) and malaise. Review of the discharge return anticipated Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #36 was frequently incontinent of bowel and bladder and required partial/moderate assistance with toileting hygiene.Review of the care plan dated 04/27/26 revealed Resident #36 had potential for bladder incontinence related to required assistance with ADL. Interventions included assisting to the bathroom with usual rounds and on demand and to clean peri area with each incontinent episode.Observation on 04/27/2026 at 11:03 A.M. of incontinence care for Resident #36 provided by Certified Nursing Assistant (CNA) #721 revealed upon entering the room, Resident #36 was lying in bed. CNA #721 entered the room and revealed she was going to provide incontinence care. CNA #721 revealed Resident #36 had a sore bottom, she did not have any dressings on her bottom, it was just dry. CNA #721 revealed she started her shift at 6:00 A.M. and revealed this was the first time today she had time to check Resident #36 for incontinence. CNA #721 positioned Resident #36 on her side. Resident #36's brief was saturated with urine; the pad and sheet Resident #36 was lying on was also saturated. Resident #36's buttocks were also red and excoriated. Interview on 05/05/2026 at 12:58 P.M. with Director of Nursing (DON) revealed incontinent residents should be checked every two hours for incontinence and changed if needed.Review of the facility policy titled, Perineal Care, dated 11/26/25, revealed it is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown.This deficiency represents non-compliance investigated under Complaint Numbers 2679780, 2626312, 2582798, 1354209 (OH00163040) and 1354208 (OH00162319).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview, review of facility transportation logs and review of facility policy, the facility failed to ensure appointments were scheduled, transportation was arranged and appointments were attended as ordered by the physician. This affected one resident (#22) of three residents reviewed for appointments outside of the facility. The facility census was 52.Findings include:Review of the medical record for Resident #22 revealed an admission date of 02/22/24. Diagnoses included Multiple Sclerosis, overactive bladder, chronic pain syndrome, and history of other diseases of the digestive system. Review of the 03/11/26 quarterly Minimum Data Set (MDS) 3.0 for Resident #22 revealed a Brief Interview of Mental Status (BIMS) of 15 which indicated intact cognition. Resident #22 was noted to require set up for toileting hygiene and noted to be occasionally incontinent. Review of the nursing progress note dated 06/23/25 at 6:37 A.M. for Resident #22 revealed on the evening of 06/22/25, Resident #22 complained of nausea and then at 5:30 A.M. she was noted to have had a moderate amount of coffee ground emesis. The physician was notified and gave an order to send Resident #22 out to the emergency department (ED) for evaluation and treatment.Review of the nursing progress note dated 06/23/25 at 12:07 P.M. revealed Resident #22 was admitted to the hospital with a diagnosis of perforated small intestine with surgery to be completed that afternoon.Review of the hospital after visit summary for Resident #22 dated 07/07/25 revealed the resident underwent laparoscopy converted to laparotomy with lysis of adhesions and release of small bowel obstruction and drain placement on 06/23/25. Review of the follow-up appointments needed for Resident #22 revealed a gastroenterology appointment to be scheduled for two weeks post op and a surgical post op follow up appointment to be scheduled for two weeks following surgery.Review of the nursing progress notes from 07/07/25 to 08/30/25 revealed no evidence of either follow up appointments were scheduled or documented.Review of the July and August 2025 physician orders, Medication Administration Records (MAR) and Treatment Administration Records (TAR) for Resident #22 revealed no documented evidence of a physician order for the post-operative follow-up appointments being scheduled.Interview on 05/04/26 at 3:20 P.M. with MDS Coordinator #621 confirmed when Resident #22 came back from the hospital on [DATE], she was supposed to have two follow-up appointments scheduled for two weeks following surgery.During a telephone interview on 05/04/26 at 3:40 P.M. Physician Receptionist #822 confirmed Resident #22 had a follow-up gastroenterology appointment on 07/22/25 at 10:00 A.M. but did not show up for the appointment.During a telephone interview on 05/04/26 at 3:45 P.M. Physician Receptionist #821 confirmed a surgical follow-up appointment was never scheduled for Resident #22.Interview on 05/05/26 at 12:54 P.M. with Staffing Coordinator #712 revealed she was unsure who made the surgical post-operative appointment on 07/22/25 but was the one who scheduled transportation for the appointment. Staffing Coordinator #712 stated she told Resident #22 the day before about the appointment and after transport arrived on 07/22/25, the resident refused to go to the appointment. Review of the facility form titled Appointments revealed Resident #22 had a 10:00 A.M. appointment scheduled on 07/22/25 for a follow up with the gastroenterologist. Transport was noted to be arranged with a pickup time between 9:20 A.M.-9:30 A.M. At the bottom of the form, it stated Resident #22 had refused the appointment after transportation arrived. Phone interview on 05/05/26 at 1:13 P.M. with Transport Company Manager #830 confirmed there was no scheduled pick up for Resident #22 on 07/22/25.Interview on 05/05/26 at 2:32 P.M. with the Administrator confirmed the facility was unable to provide additional evidence that transportation had been arranged for Resident #22's gastroenterology appointment scheduled for 07/22/25 and was unable to provide evidence a surgical follow-up appointment was scheduled following her hospital discharge on [DATE].Review of the 08/25/25 facility policy called Scheduling of Resident Appointments revealed the purpose was to ensure resident medical, therapeutic, and ancillary appointments are scheduled, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	coordinated and completed in a timely manner to promote continuity of care, resident safety and positive health outcomes. This deficiency represents non-compliance investigated under Complaint Number 1354208 (OH00162319).

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, and review of the facility policy, the facility failed to perform hand hygiene and change gloves between treating multiple wounds on Resident #5 during wound care observation and did not cleanse each wound prior to treatment. This affected one resident (#5) of two residents observed for wound care. The facility census was 52.Findings include:Record review for Resident #5 revealed an admission date of 03/30/26. Diagnoses included chronic systolic congestive heart failure, acute kidney failure and weakness.Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 was cognitively intact. Resident #5 was dependent on staff for toileting hygiene, chair/bed to chair transfer and required partial/moderate assistance for bed mobility. Resident #5 had three Stage II pressure ulcers (partial thickness loss of dermis presenting as a shallow open ulcer with a red, pink wound bed, without slough, may also present as an intact or open/ruptured serum filled blister) that were present on admission and received applications of non-surgical dressings. Review of the care plan dated 04/09/26 revealed Resident #5 had skin breakdown/open area/pressure ulcer to bilateral buttocks related to limited mobility and noncompliance with intervention for prevention, was present upon admission. Interventions included completing the treatment as ordered per physician. Review of the physician orders for Resident #5 revealed:- Wound Care to the right medial buttocks apply Triad cream (a zinc-oxide based paste to treat wounds) and dry dressing three times a week and as needed if loose or soiled. The order start date was 04/28/26 and discontinued on 04/29/26 at 11:51 A.M. by Assistant Director of Nursing (ADON) #649.- Wound care to the right lateral buttocks, apply Triad cream and a dry dressing three times a week and as needed if loose or soiled. The order start date was 04/28/26 and the order was discontinued on 04/29/26 at 11:54 A.M. by ADON #649.- Wound Care: Skin tear to sacrum. Apply Triad cream and cover with a dry dressing three times a week and as needed if loose or soiled. The order start date was 04/28/26 and end date 04/29/26 and discontinued 04/29/26 at 11:56 A.M. by ADON #649.- Wound care to the skin tear to the right posterior thigh: Apply Triad cream to open area and cover with a dry dressing three times a week and as needed if loose or soiled. The order start date was 04/28/26 and discontinued on 04/29/26 at 11:58 A.M. by ADON #649.Observation on 04/29/26 at 11:11 A.M. of Registered Nurse (RN) #648 and Licensed Practical Nurse (LPN) #619 provide wound care for Resident #5 revealed LPN #619 removed the dressing to Resident #5's right buttocks. LPN #619 confirmed there were no dressings on the wounds to the sacrum, right posterior thigh or the open area on the left buttocks. LPN #619 revealed the dressings must have fallen off and no one reported it to the nurse. After removing the dressing to the right buttocks, LPN #619 washed her hands and applied clean gloves. LPN #619 then applied Triad cream to the wound (never cleansed the wound prior to the new treatment) then a border foam dressing. LPN #619 then confirmed the open area to the left buttocks, revealed there should have been a dressing over the wound, applied Triad cream and a border foam dressing (LPN #619 never washed her hands or changed her gloves prior to moving from the wound on the right buttocks to the wound on the left buttocks and never cleansed the wound prior to adding a new treatment.) LPN #619 requested RN #648 go to the treatment cart and obtain saline to clean the wound to the sacrum because she could not see the wound due to heavy white cream. After RN #648 returned with the saline solution, LPN #619 cleansed the sacral wound with normal saline (never removed her gloves or cleansed her hands from completing wound care to the left buttocks). After cleansing the wound, LPN #619 then removed her gloves and washed her hands then applied Triad cream and a foam dressing. LPN #619 then applied Triad cream and a foam dressing to the open area to the right posterior thigh (LPN #619 never cleansed the wound prior to applying a new treatment).Interview on 04/29/26 at 11:43 A.M. with LPN #619 who stated, Wound care, cleansing wounds depends on orders, some wounds we do clean and some we don't depending on orders. LPN #619 picked up a copy she had of Resident #5's (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound care orders she brought to Resident #5's room with her, showed the wound care orders to the surveyor and confirmed none of the orders had instructions to cleanse the wound prior to initiating the treatment. LPN #619 then revealed, My thought was I wasn't removing anything old between wounds so deemed not necessary to change gloves or wash hands. LPN #619 revealed she provided incontinence care earlier and there were no dressings on the wounds except for the right buttocks and revealed she was not sure how long the dressings had been off. Interview on 04/29/2026 at 11:47 A.M. with Wound Care Nurse/Assistant Director of Nursing (ADON) #649 revealed anyone should always clean a wound prior to initiating a new treatment. Wound Care Nurse/ADON #649 reviewed the physician orders for Resident #5 and confirmed the orders did not specify to cleanse the wounds prior to treatment. Wound Care Nurse/ADON #649 stated, They should have cleansed the wounds, that was an error inputting the order; you should always clean a wound before doing the treatment and should wash hands and change gloves between wounds. Wound Care Nurse/ADON #649 revealed Resident #5 should have had dressings on each wound or the first person to notice there was no dressing, should have reported it.A review of the facility policy titled, Pressure Injury Prevention and Management, dated 03/31/26, revealed that the nurse's failure to cleanse each wound before treatment and failure to perform hand hygiene between treating multiple wounds on the same resident were not consistent with established facility standards. The policy requires that licensed nurses conduct full skin and wound assessments and implement evidenceˆbased interventions that prevent infection and support wound healing, including keeping the skin clean and minimizing contamination risk (Policy Sections 3c, 4c, and 4d). The policy further mandates that wound treatment decisions be based on wound characteristics such as exudate, odor, tissue condition, and infection indicators (Section 4d), all of which require proper cleansing before any dressing or intervention is applied to ensure accurate assessment and reduce infection risk. Additionally, the policy establishes that interventions must follow professional standards of practice and must be implemented consistently to prevent avoidable pressure injuries and complications (Sections 1-2 and 4). By not cleansing the wounds and not performing hand hygiene between separate wound sites, the nurse did not follow the infectionˆprevention principles embedded within the policy's requirements for prompt assessment and treatment, intervening to prevent infection, and evidenceˆbased treatments necessary to promote healing and prevent crossˆcontamination.The deficient practice represents noncompliance investigated under Complaint Number 2582798.

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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 record review, observation, facility policy review and staff interview, the facility failed to ensure fall prevention interventions were implemented for Residents #8 and #69. This affected two residents (#8 and #69) of four residents reviewed for accidents. The facility census was 52.Findings include:1. Review of the medical record for Resident #8 revealed the resident was admitted to the facility on [DATE] with diagnoses including epilepsy, diabetes mellitus, and dysphagia. Review of the care plan, dated 01/05/23 with a revision on 06/05/24, revealed Resident #8 was at risk for falls related to poor safety awareness, unsteady gait, risk of medication side effects, and incontinence. Interventions dated 06/05/24 included ensuring the call light was within reach and nonskid footwear when out of bed. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #8 was severely cognitively impaired and was dependent on staff for all activities of daily living (ADL) except for substantial assistance was required with eating. Further review revealed that Resident #8 had no falls. Observation on 04/27/26 at 8:57 A.M. revealed that Resident #8's call light was not within reach. Resident #8 was sitting in her wheelchair away from the bed. The bed was against the wall with a fall mat on the floor next to the bed and the call light was lying on the bed. Resident #8 did not have nonskid socks on, and the legs were not on the wheelchair. Licensed Practical Nurse (LPN) #619 verified the findings at the time of the observation. 2. Review of the medical record revealed Resident #69 was admitted to the facility on [DATE]. Diagnoses included benign neoplasm of brain, weakness, syncope and collapse, spinal stenosis and dorsalgia (back pain). Review of Resident #69's baseline care plan dated 04/16/26 identified the resident as at risk for falls and documented specific interventions, including keeping the bed in the low position, assisting with ADL, ensuring proper footwear, keeping pathways free from clutter, ensuring the call light was within reach, and reminding the resident to call for assistance. Review of the fall risk assessment dated [DATE] revealed Resident #69 had multiple high-risk factors for falls. Review of the nurses note dated 04/27/26 at 7:48 A.M. revealed Resident #69 was observed supine on floor of own room following morning medication administration without truncal support. Integumentary system assessed and observed to be without acute injury. No deviation in baseline orientation. Observation on 04/29/26 at 9:44 A.M. revealed Resident #69 was observed lying in bed with the bed not in the low position, contrary to the documented fall-prevention interventions. LPN #692 verified that the bed was not in the low position at the time of the observation and stated the bed should have been in the low position for the resident. Interview on 04/29/26 at 10:10 A.M. with Certified Nursing Assistant (CNA) #661 confirmed she had (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assisted Resident #69 back to bed earlier in the day and stated she did not know the bed should be in the low position, indicating a lack of staff awareness and failure to implement the care-planned intervention. Review of the facility's Fall Prevention Program Policy (revised 2025) revealed the following required fallˆprevention measures: Universal environmental interventions must be implemented for all residents, including ensuring the call light and frequently used items are within reach. Staff must ensure the bed is locked and lowered to a height that allows the residents' feet to be flat on the floor when sitting on the edge of the bed. Interventions identified on the fallˆrisk assessment must be incorporated into the baseline care plan and implemented by staff. Environmental hazards and individualized fallˆrisk factors must be monitored, and the care plan must be revised as necessary. This deficiency represents non-compliance investigated under Complaint Numbers and 2626312, 1354210 (OH00162542), and 1354209 (OH00163040).

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to implement pharmacy recommendations from its monthly drug regimen review for one resident (#33) of five residents reviewed for unnecessary medications. The facility census was 52.Findings include:Record review for Resident #33 revealed an original admission date of 07/17/25 with a readmission date of 09/09/25. Diagnoses included generalized anxiety disorder and depression. Review of the Modification of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #33 was cognitively intact. Resident #33 was feeling down, depressed or hopeless, had trouble falling or staying asleep, had been feeling bad about himself, felt he was a failure or have let himself or his family down, and had trouble concentrating on things. Review of the care plan dated 09/12/25 revealed Resident #33 had a psychosocial wellbeing problem related to anxiety, depression, recent admission, repeat hospitalizations and a recent right and left below the knee amputation. Interventions included anticipating needs in advance and meeting as able. Record review of the physician orders for Resident #33 revealed an order with a start date of 09/17/25 for Ativan oral tablet (antianxiety) 0.5 milligrams (mg) give one tablet by mouth every 12 hours as needed for anxiety, hold from 09/18/25 to 09/19/25. The order was discontinued 11/12/25.Record review with the Director of Nursing (DON) on 04/28/26 at 1:10 P.M. of the Pharmacy Recommendation for Resident #33 with a recommendation date of 09/22/25 revealed under Findings/Recommendations: Resident has a PRN (as needed) order for the psychotropic, lorazepam (Ativan) 0.5 mg. Per centers of Medicare and Medicaid (CMS), PRN psychotropic medications are limited to 14 days. If use is beyond 14 days, the rationale and estimated duration of use must be documented. Please choose one of the following to comply with CMS regulations: Discontinue PRN or Add __ day stop date. Three boxes were available (Agree, Disagree or other) for the physician to complete the form. The DON confirmed the form was never completed. Review of the Medication Administration Records (MAR) for September, October, and November 2025 revealed Resident #33 was administered the Ativan by nurses 14 times in September 2025, 26 times in October 2025 and two times in November 2025. The DON confirmed the pharmacy review was not completed and the nurses continued to administer the medication for the months of September, October, and November 2025.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365774	A. Building B. Wing	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medina Bsd Opco LLC	550 Miner Dr Medina, OH 44256

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on record review, observation, and staff and resident interviews, the facility failed to ensure that clinically diagnosed food allergies were accurately identified, documented, communicated, and honored for Resident #57. This affected one resident (#57) out of three residents reviewed for nutrition. The facility census was 52.Findings include:Review of the medical record for Resident #57 revealed an admission date of 03/26/26 with diagnoses including diabetes mellitus, chronic obstructive pulmonary disease, and anxiety disorder. Resident #57 had documented food allergies to banana, dairy products, fish, gluten, lactose, peanuts, porkˆderived products, soy, and tomatoes as recorded in the electronic medical record.Review of the physician's orders and the diet ticket for April 2026 revealed an order for a lowˆconcentratedˆsweets diet with regular texture and liquids. The diet ticket incorrectly listed only shellfish and peanuts as allergies, omitting multiple documented allergies including gluten, lactose, soy, and others.Observation of the lunch tray pass on 04/27/26 at 11:48 A.M. showed that Resident #57 received beef tips, noodles, a breadstick, and cake-items inconsistent with his documented allergies (e.g., glutenˆcontaining foods). Social Service Designee (SSD) #603 verified the tray contents. Resident #57 stated he did not request or consume chocolate milk and expressed reluctance to raise concerns.Interview with the Dietary Manager (DM) #689 on 04/27/26 at 3:05 P.M. revealed she had collected preferences from Resident #57 and had no documentation that glutenˆfree requirements were allergies rather than preferences.Interview on 04/27/26 at 4:41 P.M. with the Director of Nursing (DON) verified Resident #57's electronic record stated he was allergic to gluten, and the diet ticket did not reflect his allergy.Interview with SSD #603 at 4:53 P.M. on 04/27/26 confirmed the presence of glutenˆcontaining foods on the lunch tray.Interview with the Registered Dietitian (RD) #825 at 1:23 P.M. on 04/28/26 indicated she performed monthly tray audits and that the DM was responsible for entering allergy and preference information. The RD stated that documented allergies had been reviewed with the DON and DM and clarified with the resident's sisters; however, the diet ticket still did not reflect the full allergy list.Interview with Resident #57 on 04/29/26 at 8:22 A.M. indicated he only received a standard menu and no alternate options that would accommodate his allergies.A separate interview with the DON on 05/05/26 at 2:43 P.M. revealed the facility had no policy differentiating allergies from preferences, contributing to inconsistent documentation and communication of allergy information.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and facility policy review, the failed to provide liquids at the ordered consistency for Resident #68. This issue affected one resident (#68) of two residents reviewed for thickened liquids. The facility identified two residents (#13 and #68) with orders for thickened liquids. The facility census was 52.Findings include:Resident #68 was admitted on [DATE] with diagnoses including dysphagia, chronic obstructive pulmonary disease, and anxiety disorder. The admission MDS 3.0 was still in progress. Physician orders for April 2026 specified a no added salt diet with pureed texture and nectar-thick liquids. The resident also required a divided plate. The diet ticket matched these orders, listing NAS diet, pureed texture, and nectar-thick cranberry juice and milk.On 04/27/26 at 9:04 A.M., Resident #68 was observed eating breakfast. The cranberry juice provided was nectar thick, but the milk appeared thinner than the ordered consistency. At 9:05 A.M., the Assistant Director of Nursing (#649) confirmed the issue and thickened the milk to nectar consistency.On 04/29/26 at 8:42 A.M., the breakfast tray did not include milk or cranberry juice; instead, it had two eightˆounce glasses of nectar-thick water. Resident #68 reported liking cranberry juice. Transportation Scheduler (#684) confirmed the resident did not receive his preferred thickened liquids and stated she would contact the kitchen.During an interview on 04/29/26 at 9:00 A.M., the Dietary Manager (#689) stated the kitchen only had pre-thickened apple juice and water. She explained that because no pre-thickened cranberry juice was available, and she did not want incorrect thickening to lead to issues with nursing, the dietary department did not provide cranberry juice to Resident #68. She also stated he was the only resident receiving nectar-thick liquids, although the facility identified two residents (#13 and #68) with thickened-liquid orders.On 04/29/26 at 1:23 P.M., the Registered Dietitian (#825) stated she conducts a monthly tray audit and clarified that while pre-thickened juices are available, milk must be thickened in-house.A review of the facility's undated policy, Thickened Liquids (In-House Preparation), states that any liquid requiring thickening must be prepared to the correct consistency if not provided as such.

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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 observation, interview, and record review, the facility failed to ensure complete and accurate medical record documentation for one resident (#5) of two residents reviewed for wound care. The facility census was 52.Findings include:Record review showed Resident #5 was admitted on [DATE] with multiple pressure ulcers present on admission. Physician orders dated 04/28/26 directed the application of Triad cream and dry dressings to four wound sites.On 04/29/26 at 11:11 A.M., the surveyor observed Licensed Practical Nurse (LPN) #619 perform wound care for Resident #5. During this observation, LPN #619 did not cleanse multiple wounds before applying new treatments, did not consistently change gloves or perform hand hygiene between wound sites, and identified a wound that should have had a dressing in place but did not. LPN #619 also confirmed that none of the wound care orders included instructions to cleanse wounds prior to treatment.During the interview at 11:47 A.M., the Wound Care Nurse/Assistant Director of Nursing (ADON) #649 stated that all wounds should always be cleansed prior to treatment and acknowledged that the omission of cleansing instructions in the orders was an input error.Following this discussion with the surveyor, record review showed that the Wound Care Nurse/ADON #649 discontinued all four wound care orders between 11:51 A.M. and 11:58 A.M. on 04/29/26-after the incorrect wound care procedures were observed and discussed, confirming the orders had been active at the time the wound care was performed.Review of the April 2026 Treatment Administration Record (TAR) showed no active orders documented for the wound care performed on 04/29/26 at 11:11 A.M., and no signed entries indicating the observed treatments were completed.