STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365780	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marietta Heights Post Acute	5001 State Route 60 Marietta, OH 45750

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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 - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice when the facility failed to timely ensure outside facility appointments were maintained. This affected one resident (#3) of 15 residents reviewed. The census was 48.Findings include:Record review revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including polyneuropathy, end stage renal disease, atrial fibrillation, cardiomyopathy, thoracic aortic aneurysm, aphasia, type 2 diabetes, hypertension, gout, chronic pain syndrome, and acute kidney injury.Review of Resident #3's quarterly minimum data set (MDS) completed on 08/04/25 revealed a brief interview for mental status score (BIMS) of 13. Section M for skin conditions revealed Resident #3 had diabetic foot ulcers with application of dressing to feet.Review of Resident #3's record revealed an order dated 08/28/25 to cleanse diabetic ulcer to left foot with in house wound cleanser and pat dry, apply medi- honey and cover with foam every day shift every other day and as needed for wound care. Review of Resident #3's record revealed an order dated 07/08/25 to apply Opti foam dressing to right foot for protection three times weekly everyday shift Tuesday, Thursday, and Saturday and as needed for wound care.Review of Resident #3's record revealed an admission comprehensive skin assessment completed 04/29/25 with a right plantar wound 0.1 centimeter (cm) in depth, 2.5 cm in width, and 2.0 cm in length.Review of Resident #3's record revealed an admission comprehensive skin assessment completed 04/29/25 with a left plantar wound 8.5 cm in length, 9.5cm in width, and 0.1 cm in depth.Review of Resident #3's record revealed a skin and wound evaluation completed 08/07/25 revealed the resident has a diabetic right medical foot wound present on admission, 0.1cm squared in area, 0.5 cm in length, and 0.2cm in width. The wound is 0.1cm in depth.Review of Resident #3's weekly comprehensive skin evaluation completed 08/21/25 revealed Resident #3 has one or more newly identified or existing wounds or skin integrity concerns. Site is a left heel pressure.Review of Resident #3's record revealed a skin and wound evaluation completed 09/03/25 for left plantar foot diabetic wound, present on admission. Measurements are 2.3cm squared in area, 2.1 cm in length, 1.5 cm in width, and 0.1 cm in depth.Review of Resident #3's progress notes revealed a note dated 08/23/25 at 4:41 P.M. revealed Resident #3 had a wound center appointment for 08/26/25.Record review revealed a progress note dated 08/26/25 at 7:26 A.M. stating Resident #3 was in the hospital. Review of progress notes revealed Resident #3 was in the hospital from [DATE] through 08/27/25.Review of Resident #3 progress notes revealed no documentation of attempts to reschedule wound care appointments for Resident #3.Review of Resident #3 discharge record for the hospital on [DATE] revealed no evidence or documentation of a wound care appointment being scheduled due to missing their appointment on 08/26/25.Review of Resident #3 active, completed, and discontinued orders revealed no active ordered appointment for wound care center follow up after 08/19/25Record review revealed no documentation of any follow up with wound care center for Resident #3.Record review of Resident #3 wound care clinical document last visit with wound care was on 08/19/25 with a recommended follow up appointment within one week.Interview on 09/04/25 at 3:12 P.M. with Receptionist #1002 of Resident #3 wound care center revealed Resident #3 was not at their (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	appointment on 08/26/25 due to being in the hospital. Receptionist #1002 confirmed no appointment has been rescheduled at this time for Resident #3.Interview on 09/04/25 at 4:00 P.M. with Assistant Clinical Regional Director #167 stated Resident #3's wound care appointment that was canceled on 08/26/25 was rescheduled by the hospital while she was inpatient there. Assistant Clinical Regional Director #167 confirmed there was no documentation of this or evidence an appointment was scheduled.

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff schedule review, facility assessment review, resident council meeting minute review, resident interview and staff interview, the facility failed to provide sufficient staffing to meet the needs of residents in a timely manner. This had the potential to affect all 48 residents residing within the facility. The facility census was 48.Findings Include: Review of the Facility assessment dated [DATE] revealed the assessment will inform the facility's staffing decisions to ensure there are a sufficient number of staff with appropriate competencies necessary to care for residents' needs as identified through resident assessments and plans of care. The facility will consider staffing needs for each resident unit in the facility for each shift and adjust a necessary based on resident population. The facility's contingency plan includes processed to ensure that staffing needs are addressed as they arise. In an unplanned staffing need, the facility uses on-call nurse management to either fill the shift or find appropriate replacement through the utilization of staff call sheets to ensure all facility staff are contacted. This facility assessment was provided by Operational Support #164 on 09/03/24. Review of the Resident Council Meeting Minutes dated 04/21/25 revealed residents voiced concerns that it took too long to answer call light and find additional help if needed on the weekends. Residents also stated they had a hard time finding someone to take them out to smoke. Review of the Meeting Minutes dated 05/19/25 revealed all old business issues had been resolved; however, there was no evidence the staffing concerns voiced related to staffing were address or call light audits completed. Review of the Resident Council Meeting Minutes dated 08/18/25 revealed residents voiced concerned about how long it takes to get a second set of hands to have the hoyer (mechanical lift) used. On 09/03/25 at 10:52 A.M. during the Resident Council Meeting, six residents (#5, #11, #16, #17, #31 and #32) were in attendance and stated residents had to wait for the mechanical hoyer lift but the nursing staff was doing the best they could, with what they had. Residents stated there was one aide for two halls the other day, smoking was pretty rare as there was not a lot of people available to take you out especially on the weekends. Review of the undated Nursing Staff Ladder for 24 hour period revealed total number of nursing staff for a census of 48 residents was three aides on days, three aides on nights and 5.33 total number of floor nurses. Review of the Staffing Schedules dated 06/30/25 to 07/06/25 revealed there were two Certified Nurse Aides (CNA) for eight hours and one CNA for three hours that worked between 7:00 A.M. and 3:00 P.M. on 07/03/25. The resident census was 48. On 09/02/25 at 9:20 A.M. phone interview with the local Ombudsman was completed. The Ombudsman shared they were aware of staffing concerns in the facility that had previously been brought to their attention that they were currently following up with during their onsite visits at the facility. On 09/02/25 at 10:07 A.M., interview with Resident #49 stated the call light takes a minimum of 30 minutes to answer, they will have only one aide per hall and so residents cannot go to dining room for (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	meals. Resident smoke breaks are late or no aide with you. On 09/02/25 at 10:39 A.M., interview with a resident who wishes to remain anonymous stated there was not enough staff to get her complete bed baths when scheduled and it takes up to 30 minutes for call lights to get answered. On 09/02/25 at 11:22 A.M., interview with a resident who wishes to remain anonymous stated sometimes have to wait a long time for call light to be answered (30 minutes). The resident was not provided the assistance needed to complete bathing activities of her choice when scheduled on 08/30/35 and nail care was not provided when needed during the course of the biannual survey. On 09/02/25 at 1:26 P.M., interview with a resident who wishes to remain anonymous stated staffing was low on the weekends related to call-offs and has had to wait 30-60 minutes for call light response. On 09/02/25 at 3:14 P.M., interview with a resident who wishes to remain anonymous stated the facility needs more aides so they can be better cared for. The resident stated there were only two nurses and two aides on the weekend. On 09/03/25 at 3:42 P.M., interview with CNA #153 stated she did not think there was enough staff because a lot of the residents require two assist and it's hard to find someone to help you. I always stay over to get my workload done. I can't say I do two hours checks because I don't. I do try, but there's too much to do. On 09/04/25 between 6:50 A.M. and 6:58 A.M., interview with Licensed Practical Nurse (LPN) #126 stated do not always work with a full staff of aides to manage all three halls. When there is a call-off, if agency doesn't pick up the shift, they tell us to use the staff they have to 'make it work'. Resident showers, as well as, check and change every two hours do not always get done. On 09/04/25 at 7:08 A.M., interview with Anonymous Employee #138 who wishes to remain anonymous revealed call lights can take longer than 30 minutes at times to be answered. There are currently no restorative or toileting programs being implemented and when there are only two aides on nights, resident's are not getting their showers because doing their best trying to make rounds to get everyone toileted and changed a couple times through the night. Turning and repositioning is done when they get to change the residents and there are a lot of two-assist dependent residents to care for. All nurses do not help and when their are call-offs management doesn't always come in when called and they tell them to do the best they can. Showers don't get done and it's not fair to the residents but the facility can't keep staff. If a resident gets sick or having a bad night, they take priority over showers and other care needs and once they are okay, they just keep going to get everyone looked at. Stated it is better than it was but care is compromised when only have two aides for the entire building. On 09/04/25 between 7:15 A.M., interview with an Anonymous Employee #147 stated weekends have just two aides during the night shift and that makes it really hard and cannot get scheduled resident showers done. Try to pass ice at beginning of shift and do a quick check on everyone because the rest of the time you are busy doing check and changes, once you get done with your first round, you are already late getting to the residents who were changed first. Do the best they can. On 09/09/25 at 3:07 P.M., interview with LPN #104 states facility uses agency when needed to help maintain adequate staffing. LPN #104 feels currently there is enough staff with management help on the day shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/04/25 between 6:34 A.M. and 6:45 A.M., interview with LPN #120 stated the staffing levels have improved and use agency staff when needed. LPN #120 stated the staffing has improved over the last several weeks but weekends continue to be a struggle and residents have to wait for care. On 09/08/25 at 1:40 P.M., interview with CNA #129 stated residents cannot smoke without staff and sometimes there just isn't enough time to get it all done and take them to smoke. There have been times when there just wasn't enough staff to take the residents who wanted to smoke at the scheduled times due to resident care that had to be provided to another resident. On 09/09/25 at 10:06 A.M., interview with Central Supply (CS) #100 stated stated she was also the staffing coordinator and both temporary and contractual staff were being used. CS #100 stated it was the expectation if call offs were unable to be covered by facility staff or temporary staff, the nurse management on-call staff would come in to cover the shift. This deficiency represents non-compliance investigated under Complaint Intake Number 259304.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review, the facility failed to maintain the kitchen in a sanitary manner. This affected 47 of 48 residents who receive meals from the kitchen The facility identified one resident who did not receive nutrition from the kitchen. The facility census was 48. Findings include:Observation of the kitchen on [DATE] starting at 8:29 A.M. revealed splatters on the backsplash and walls behind the over and stove area, grime on the toaster oven controls, debris on the shelves containing hot-well pans, splatters on the wall behind the juice machine, and a half-full 19-ounce container of sesame seeds which expired on [DATE]. Interview on [DATE] with [NAME] #149 confirmed the splatters on backsplashes and walls, grime on toaster oven controls, debris on shelves containing clean hot-well dishes, and the expired container of sesame seeds. Review of a policy titled Sanitation dated 04/2006 revealed all kitchens, kitchen areas, and dining areas shall be kept clean, free from litter and rubbish. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and free from breaks, corrosion, open seams, cracks and chipped areas that may affect their use or proper cleaning. Kitchen and dining room surfaces should be on a regular schedule and frequently enough to prevent the accumulation of grime.

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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 observation, record review, policy review and interview, the facility failed to develop and implement a comprehensive and effective infection control program to prevent the spread of infection. The facility failed to ensure hand hygiene was performed during care, failed to ensure the infection control log was complete and accurate and failed to follow the water management plan for Legionella per facility policy. This affected two (#1 and #3) residents reviewed for wound care, six residents (#19, #17, #4, #11, #21 and #36) reviewed on the facility infection control log and had the potential to affect all 48 residents residing in the facility. Findings include: 1.Review of the infection control log for April 2025 revealed Resident #19 had a wound infection. The signs and symptoms were not listed; Resident #17 was listed for an unknown infection with no signs or symptoms listed; Resident #4 was listed with an unknown infection with no signs or symptoms listed; and Resident #11, #21, and #36 had not been included in the printed log but were penciled in at the bottom left corner of the log with no information regarding where the infections were acquired, signs and symptoms, and treatment. Review of the infection control log for May 2025 revealed Resident #17 had an unknown infection with no signs or symptoms listed. Review of the infection control log for June 2025 revealed Resident #17 had an unknown infection with no signs or symptoms listed; and Resident #29 had an unknown infection with no signs or symptoms listed. Interview on 09/09/25 with Director of Nursing (DON) revealed the infection control log is generated from the electronic chart so she was not sure why areas of the infection control log were blank and why some residents were left off and had to be added by hand. The DON confirmed the log should be completed entirely. Review of a policy titled Surveillance for Infections (dated April 2025) revealed the infection preventionist or designee is responsible for gathering and interpreting surveillance data which would include lab results, skin care sheets, infection control rounds or interviews, verbal reports from staff, infection documentation records, temperature logs, pharmacy records, antibiotic review, and transfer log/summaries. For residents with infection that meet criteria for definition of infection for surveillance, collect data such as identifying information, diagnoses, admission date or date of onset of infection, infection site, pathogens, invasive procedures or risk factors, pertinent remarks, and treatment measure and precautions. 2.Review of an undated document titled Control Measure and Corrective Action revealed the facility's legionella monitoring would include a six month cleaning cycle for the ice machine and a monthly filter check; removing any dead legs in the building; run hot and cold water in the less frequently used areas of the building weekly for three minutes including soiled linen rooms, medication rooms, shower room, bath tub in private room, and empty resident rooms; checking water heaters for leaks and flushing the tank to remove sediment buildup, test the pressure relief valve, check the circulation pump, ensure mixing valves are operational and clean, and check the thermostat is working properly; clean the respiratory therapy equipment weekly; PTAC filters are checked and cleaned monthly; faucet aerators and shower heads are on a cycle to be either disinfected or replaced with new; and the juice machine gun to be soaked daily by dietary staff in disinfectant and taken apart weekly for cleaning. Review of Water System Infection Control Log revealed legionella control plan had not been followed (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	since 03/19/25. Interview on 09/09/25 at 3:29 P.M. with Regional Registered Nurse confirmed the facility did not have additional information for evidence the legionella control plan was followed since 03/19/25. Review of an undated policy titled Legionella Water Management Program revealed the water management team consists of the infection preventionist, administrator, medical director, director of maintenance, and director of environmental services and they are in charge of overseeing the water management program. 3.Record review revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including polyneuropathy, end stage renal disease, atrial fibrillation, cardiomyopathy, thoracic aortic aneurysm, aphasia, type 2 diabetes, hypertension, gout, chronic pain syndrome, and acute kidney injury. Review of Resident #3's quarterly minimum data set (MDS) completed on 08/04/25 revealed a brief interview for mental status score (BIMS) of 13. Section M for skin conditions revealed Resident #3 had diabetic foot ulcers with application of dressing to feet. Review of Resident #3's care plan implemented 06/11/25 revealed resident has impaired skin integrity on admission as evidenced by diabetic ulcers. Interventions include administer treatments as ordered and monitoring for effectiveness. Review of Resident #3 care plan initiated 07/14/25 revealed the resident requires enhanced barrier precautions (EBP) during high- contact resident care activates due to the presence of chronic wounds. Interventions include hand hygiene utilizing alcohol-based hand rub (ABHR). Review of Resident #3 record revealed an order dated 08/28/25 to cleanse diabetic ulcer to left foot with in house wound cleanser and pat dry, apply medi- honey and cover with foam every day shift every other day and as needed for wound care. Review of Resident #3 record reveled an order dated 07/08/25 to apply Opti foam dressing to right foot for protection three times weekly everyday shift Tuesday, Thursday, and Saturday and as needed for wound care. Observation on 09/04/25 at 3:30 P.M. of Licensed Practical Nurse (LPN) #189 performing wound care on Resident #3 left and right foot diabetic ulcers. LPN #189 entered the room with supplies and gown for EBP. LPN #189 placed a barrier up to place supplies down. LPN #189 applied gloves, removed dressing to left and right foot and assessed wounds and feet. LPN #189 removed gloves and reapplied new gloves with no hand hygiene. LPN #189 cleansed left foot wound with in house wound cleanser and 4x4 gauze cleaning interior to exterior. LPN #189 removed gloves, reapplied new pair of gloves without performing hand hygiene. LPN #189 used cotton swab to apply medi-honey to wound, applied Opti foam dressing. LPN #189 removed gloves and reapplied new gloves with no hand hygiene performed. LPN #189 cleansed right foot wound with in house wound cleanser and 4x4 gauze. LPN #189 removed gloves, and reapplied new pair without performing hand hygiene. LPN #189 applied optifoam dressing to right foot, removed gloves, initialed and dated dressings to left and right foot and then performed hand hygiene. Interview With LPN #189 on 09/04/25 at 3:40 P.M. confirmed she did not perform hand hygiene with (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	soap or an alcohol based hand rub (ABHR) between gloves changes during wound care for Resident #3. Review of facility policy titled Dressings, Dry/ Clean (not dated) revealed steps in the dressing change procedure included: 1. Place clean equipment on a clean field. 2. Use biohazard or plastic bag on bedside stand. 3. Position and adjust resident and resident clothing if needed. 4. Perform hand hygiene. 5. Put on clean gloves, loosen tape and remove soiled dressing. 6. Pull glove over dressing and discard, 7. Perform hand hygiene. 8. Open dry clean dressing only touching exterior of surface. 9. Label tape or dressing with date, time, and initials. Place on clean field. 10. Using clean technique open other products. 11. Perform hand hygiene. Review of Policy titled Handwashing/ Hand Hygiene (revised October 2023) revealed all personnel are trained and regularly in serviced on the importance of hand hygiene in preventing the transmission of healthcare associated infection. All personnel are expected to adhere to hand hygiene. Indications for hand hygiene include immediately before touching a resident, after contact with blood, body fluids, or contaminated surfaces, after touching a resident, after touching the resident's environment, before moving from work on a soiled body site to a clean body site on the same resident and immediately after glove removal. The use of gloves does not replace hand washing/ hand hygiene. 4. Record review revealed Resident #1 was admitted to the facility 08/30/22 with toxic encephalopathy, type II diabetes, acute kidney failure, neuromuscular dysfunction of the bladder, Methicillin resistant staphylococcus aureus (MRSA), muscle weakness, anemia, altered mental status, dysphagia, osteoarthritis, depression, hallucinations, depression, right buttock pressure ulcer stage 2, and bacteremia. Record review of quarterly Minimum Data Set (MDS) completed 06/25/25 revealed Resident #1 is always incontinent of bowel, requires max assistance for bed mobility, gas one stage three pressure ulcer and an open lesion, application of nonsurgical dressings, application of ointments or medications other than to the feet. Review of Resident #1's care plan completed 07/08/25 revealed the resident requires enhanced barrier precautions (EBP) related to infection or colonization with Multi-drug resistant organisms (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(MDRO), when contact precautions do not apply due to wound and indwelling medical device catheter. Potential spread of infectious microorganisms will be minimized through EBP. Interventions include maintain EBP for the duration of the resident stay, or until resolution of wound, discontinuing of medical device that placed resident at higher risk and utilize gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Examples of high contact interactions include dressing, bathing, showering, transferring, providing hygiene, shaving, changing linens, changing briefs/toileting, device care or use (central lines, urinary catheters, feeding tube, trach, vent, wound care, etc.) Observation on 09/08/25 at 2:26 P.M. revealed Licensed practical nurse (LPN) #115 and LPN #126 assisting Resident #1 to change her wound dressings. During wound care Resident #1 had a bowel movement. LPN #115 and LPN #126 began cleaning the bowel movement. After the resident was cleaned and assisted with incontinence care LPN #126 removed their gloves and performed hand hygiene. LPN #115 did not remove gloves or perform hand hygiene after performing incontinence care. LPN #115 then began to hand Resident #1 their call light, remote, and move the bedside table using their hands with gloves still on from performing incontinence care. Interview on 09/08/25 at 2:40 P.M. with LPN #115 confirmed they did not change their gloves, or perform hand hygiene after performing incontinence care and before touching resident's personal items. Review of facility policy titled Handwashing/ Hand Hygiene (revised October 2023) revealed all personnel are trained and regularly in serviced on the importance of hand hygiene in preventing the transmission of health care associated infections. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread if infections to personnel, residents, and visitors. Indications for hand hygiene is indicated immediately before touching a resident; after contact with blood, body fluids, or contaminated surfaces; after touching a resident; after touching the residents environment; before moving form work on a soiled body site to a clean body site on the same resident; and immediately after glove removal.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure residents or representatives were notified of bed hold days remaining and transfer to hospital as well as notification to the ombudsman. Additionally, the facility failed to ensure residents had a completed recapitulation of stay upon discharge. This affected six residents (#2, #3, #4, #19, #29, and #51) of six residents reviewed for transfer and discharge. The facility census was 48.Findings include:1.Record review revealed Resident #2 admitted to the facility on [DATE] with diagnoses including type II diabetes, mild intellectual disabilities, and anxiety disorder. Review of a nursing note dated [DATE] at 2:37 P.M. by Registered Nurse (RN) #144 revealed Resident #2's roommate approached the nurse stating she was concerned about how long Resident #2 had slept. RN #144 spoke with Resident #2 who stated she was just tired. Resident #2 was repositioned in bed and noted to be very sweaty, and her blood glucose was 198. Resident #2 had not eaten her lunch, was offered an alternative and declined stating she thought she would be able to eat dinner when it came. Review of a nursing note dated [DATE] at 12:45 A.M. by Licensed Practical Nurse (LPN) #116 revealed Resident #2 was sent to the hospital via emergency medical services due to decreased oxygen saturation. Resident #2 was found in her room resting with her eyes closed on room air without nasal cannula applied. Resident #2 was lethargic, alert and oriented times one, diaphoretic, and had a yellow tint to both eyes. Director of Nursing and physician were notified. Review of a document titled Emergency Transfer/Bed Hold Notice dated [DATE] revealed Resident #2 was transferred to a local hospital. There was no evidence of family notification of transfer, of bed hold days left, or ombudsman notification. Interview on [DATE] at 1:25 P.M. with Assistant Regional Clinical Director #167 confirmed the ombudsman was not notified of hospital transfers and there was no additional information regarding the bed hold notice or notification to Resident #2's representative. 2. Record review revealed Resident #19 admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disorder, muscle weakness, and dementia. Review of Resident #19's care plan initiated on [DATE] revealed no care plan in place for discharge planning. Review of an MDS dated [DATE] revealed Resident #19 had moderately impaired cognition and planned to remain in the facility. Review of a physician order dated [DATE] revealed Resident #19 was to discharge home on [DATE]. Review of an assessment titled Discharge Summary and Post-Care Instructions dated [DATE] revealed the assessment and instructions were completed for the social services section but were not completed for the nursing assessment. Interview on [DATE] at 12:11 P.M. with Social Worker (SW) #103 confirmed the discharge (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assessment and instructions were no completed and should be completed at the time of a resident's discharge and sent with them. 3. Record review revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including polyneuropathy, end stage renal disease, atrial fibrillation, cardiomyopathy, thoracic aortic aneurysm, aphasia, type 2 diabetes, hypertension, gout, chronic pain syndrome, and acute kidney injury. Review of Resident #3 quarterly minimum data set (MDS) completed on [DATE] revealed a brief interview for mental status score (BIMS) of 13. Review of Resident #3's progress notes revealed a note on [DATE] at 6:53 P.M. stating Resident #3 is increasingly confused. Upon assessment the resident was unable to form complete sentences with periods of staring off, unable to correctly answer questions. Family was made aware and resident was sent to the emergency room (ER) for evaluation. Review of Resident #3'd progress notes revealed a note dated [DATE] at 1:11 A.M. stating ER nurse was spoken to regarding Resident #3 and Resident #3 was being admitted for altered mental status (AMS). Review of Resident #3's progress notes revealed a note dated [DATE] at 2:11 A.M. revealed Resident #3 returned to the facility alert, and appearing tired. Review of Resident #3's record revealed an incomplete bed hold notice dated [DATE] with no documentation of the maximum number of days the bed will be held at no cost, and no documentation of maximum number of days in a calendar year the room will be reserved upon request without cost to the resident. Review of Resident #3's progress notes revealed a note dated [DATE] at 2:02 A.M. stating Resident was in her room stating there was a painful rash on her leg that was painful to the touch. There were observed multiple splotches of red rash on the residents ankle up to the groin of her whole left leg that felt hot to the touch. Medical Director notified, on call manager notified, and resident was sent to the ER. Review of Resident #3's record revealed progress notes dated [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] stating Resident #3 was out of the facility and admitted to the hospital. Review of Resident #3's progress notes revealed they were admitted to the hospital on [DATE] and returned to the facility on [DATE] at 6:45 P.M. and assisted to their room. Review of Resident #3's record revealed no documentation of a bed hold notice being provided to Resident #3 or their power of attorney for their hospital admission from [DATE] through [DATE] totaling six days. Record review of Resident #3's record revealed a progress note dated [DATE] at 11:50 P.M. stating Resident #3 had complaints of abdominal pain and was observed applying pressure to their left upper quadrant and stated they were going to throw up. Resident #3 stated she wanted to go to the hospital, physician aware. Record review of Resident #3 revealed a progress note dated [DATE] stating Resident #3 was (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	transferred to the ER. Record review of Resident #3 revealed progress notes dated [DATE], [DATE], [DATE] stating the resident was in the hospital. Record review revealed a progress note dated [DATE] stating Resident #3 arrived to the facility from the hospital and was oriented to her room. Record review revealed Resident #3 was admitted to the hospital from [DATE] through [DATE] totaling six days. Review of Resident #3's record revealed no documentation of a bed hold notice being provided to Resident #3 or their power of attorney for their hospital admission from [DATE] through [DATE] totaling six days. Record review of Resident #3 record revealed a progress note dated [DATE] at 6:24 P.M. stating resident had a sudden onset of AMS and trembling, nurse practitioner, director of nursing, and family notified. Resident transported to ER. Record review of Resident #3'd record revealed Resident #3 was admitted to the hospital for altered mental status from [DATE] through [DATE] when Resident #3 arrived to the facility on [DATE] at 8:06 P.M Record review of Resident #3'd record revealed a bed hold notice dated [DATE] stating Resident #3 has 30 days of bed hold with no cost in the calendar year left, and 30 days in a calendar year the bed will be held in the case of therapeutic leave or vacation. Record review revealed Resident #3's record revealed no documentation an ombudsman was notified of transfer for hospital admission from [DATE] through [DATE], [DATE] through [DATE], [DATE] through [DATE], and [DATE] through [DATE]. Interview on [DATE] at 1:25 P.M. with Assistant Clinical Regional Director #167 confirmed Resident #3's bed hold notice dated [DATE] had no documentation for maximum number of days, and was incomplete. Assistant Clinical Regional Director #167 confirmed there was no bed hold notice provided to Resident #3 of their family or power of attorney for their hospital admission [DATE] through [DATE] totaling six days. Assistant Clinical Regional Director #167 confirmed no bed hold notice was provided to Resident #3 or their family or power of attorney for their hospital admission [DATE] through [DATE] totaling six days. Assistant Clinical Regional Director #167 confirmed Resident #3 and their family were provided an inaccurate, incomplete bed hold notice for Resident #3's hospital admission from [DATE] through [DATE]. Assistant Clinical Regional Director #167 confirmed there was no notification to an ombudsman of transfer/discharge for hospital admission from [DATE] through [DATE], [DATE] through [DATE], [DATE] through [DATE], and [DATE] through [DATE]. 4. Medical record review revealed Resident #4 was admitted on [DATE] with diagnoses including metabolic encephalopathy, mild neurocognitive disorder with behavioral disturbances, protein-calorie malnutrition and constipation. Review of the resident Census revealed Resident #4 was discharged to the hospital on [DATE], [DATE] and [DATE]. Review of the Emergency Transfer Bed-Hold Notice dated [DATE] and [DATE], as well as, the Bed (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hold Notice dated [DATE] revealed no evidence the resident/representative was provided a comprehensive and complete bed hold notice containing all required components. There was also no evidence the Ombudsman was notified of the transfers. On [DATE] at 5:50 P.M. and on [DATE] at 12:39 P.M., interview with Assistant Regional Clinical Director #167 verified the resident/representative and ombudsman were incomplete and they were not notified of the resident transfers as required. 5. Review of Resident #51's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included a left knee sprain, heart failure, non-rheumatic aortic stenosis, presence of a cardiac pacemaker, adult-onset diabetes mellitus, chronic kidney disease, obstructive sleep apnea, umbilical hernia w/o obstruction, cellulitis, presence of unspecified artificial knee joint, and pain in left knee. He remained in the facility until [DATE], when he was transferred to the hospital, and did not return. Review of Resident #51's progress notes revealed a nurse's note dated [DATE] at 7:30 P.M. that indicated the nurse was called to the resident's room due to concerns from the occupational therapist (OT). Resident #51 was sitting on the side of bed with his oxygen hanging off his ear. His oxygen saturation level was down to 85% (92-100% was considered normal ranges). The nasal cannula was replaced into his nares and his oxygen saturation level was raised to 92%. The resident was unable to speak full sentences without becoming short of breath. He appeared pale and had periorbital edema observed. The resident was in a tripod position with pursed lip breathing during the conversation. The resident consulted with his wife and daughter and decided that he wanted to be sent to the emergency room (ER) for further evaluation. The physician was notified and emergency medical services were called for transport. He left the facility at 7:59 P.M. Review of a nurse's note dated [DATE] at 8:20 P.M. revealed the nurse attempted to obtain information from the hospital on three separate occasions to gain information on the resident's hospitalization. The resident had been admitted to the Intensive Care Unit (ICU). The resident's ICU nurse had been unavailable and a message was left for a return call to be received from the hospital. Further review of Resident #51's progress notes revealed no additional information was documented regarding the resident's disposition, after being transferred to the hospital, and admitted to the ICU. Resident #51's medical record was absent for documented evidence of the resident and/ or his resident representative being given a transfer notice or bed hold notice when he was transferred to the hospital on [DATE]. There was also no evidence of the facility notifying the Ombudsman of the resident's transfer to the hospital. On [DATE] at 1:20 P.M., an interview with Assistant Regional Clinical Director #167 revealed the facility had not been notifying the Ombudsman when residents had been transferred from the facility to the hospital. They had only been notifying the Ombudsman when a resident was discharged from the facility. She stated moving forward they would notify the Ombudsman of all transfers and discharges, at the beginning of the month, for transfers/ discharges that occurred the prior month. On [DATE] at 9:40 A.M., an interview with Social Worker #103 revealed Resident #51 was not able to be provided with a transfer notice or a bed-hold notice, when he was transferred to the hospital on [DATE]. He claimed the resident passed away while at the hospital shortly after he had arrived. He was asked to provide the date the resident expired, as the progress notes revealed he was still in the (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ICU on [DATE]. No further information was provided by Social Worker #103, as to when the resident expired in the hospital. Review of the facility's policy on Bed-Holds and Returns (not dated) revealed prior to transfers, residents or resident representatives would be informed in writing of the bed-hold and return policy. Prior to a transfer, written information would be given to the residents and the resident's representative that explained in detail: the rights and limitations of the resident regarding bed-holds; the reserve bed payment policy as indicated by the state plan (MCD residents); the facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (MCD residents); and details of the transfer (per the Notice of Transfer). A copy of the notice was to be sent to the Office of the State Long-Term Care (LTC) Ombudsman at the same time the notice of transfer or discharge was provided to the resident and representative. When residents who were sent emergently to an acute care setting, those scenarios were considered facility- initiated transfers, not discharges, because the resident's return was generally expected. Under the following circumstances, the notice was given as soon as practical but before the transfer: An immediate transfer or discharge was required by the resident's urgent medical needs. Notice of transfer was to be provided to the resident and representative as soon as practicable before the transfer and to the LTC Ombudsman when practicable (e.g., in a monthly list of residents that included all notice content requirements. Notice of facility bed-hold and return policies were provided to the resident and representative within 24 hours of emergency transfers. 6. Review of Resident #29's medical record revealed the resident was admitted to the facility on [DATE]. His diagnoses included a history of a cerebral infarction (stroke), hemiplegia and hemiparesis affecting the left non-dominant side, congestive heart failure, cholecystitis (gallbladder inflammation), peritoneal abscess, and acute pancreatitis. Review of Resident #29's census tab and Minimum Data Set (MDS) assessments in the electronic medical record (EMR) revealed the resident had two hospitalizations since the facility's last bi-annual survey. He was hospitalized between [DATE] to [DATE] and again between [DATE] and [DATE]. Review of Resident #29's progress notes revealed a nurse's note dated [DATE] at 5:15 P.M. that indicated the nurse had responded to the resident's room to answer a call light. The resident was visibly shaking and reported he was having muscle spasms and abdominal pain. He had an elevated blood pressure of 185/99 mm/hg and an elevated heart rate of 131 beats per minute. His respirations were slightly elevated at 22 respirations per minute and his oxygen saturation level was within normal limits (wnl). His change in condition was described as a sudden onset as his vital signs were wnl earlier that morning and his only complaints was diarrhea after lunch. The physician was notified and gave an order for the resident to be sent to the emergency room for an evaluation. A follow up with the emergency room later that evening at 11:03 P.M. revealed the resident had been admitted to the facility with pancreatitis and sepsis. He returned to the facility on [DATE]. Further review of Resident #29's progress notes revealed a nurse's note dated [DATE] at 3:35 P.M. that indicated the resident had complaints of pain to his abdomen around his recent surgical site. The physician was notified and gave an order for the resident to be transferred to the ER for an evaluation related to his Jackson Pratt (JP) drain (a medical device used to remove fluid from a surgical site after an operation) drain drainage and discharge. A follow up with the ER on [DATE] at 11:58 P.M. revealed the resident had fluid collected where the gallbladder was measuring 3.9 centimeters (cm) by 1.9 cm. He was transferred to a hospital in Columbus, Ohio for further treatment. He returned to the facility on [DATE]. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident #29's EMR revealed it was absent for any documented evidence of the resident and his representative being provided a transfer notice or a bed-hold notice for either hospitalization that began on [DATE] and [DATE]. There was also no evidence of the State Ombudsman being notified of the resident's transfers to the hospital on [DATE] or on [DATE]. On [DATE] at 1:20 P.M., an interview with Assistant Regional Clinical Director #167 confirmed they did not have any evidence of Resident #29 or his representative being given a transfer notice or bed-hold notice for the two separate hospitalizations that occurred in [DATE]. She further confirmed they did not have evidence of the State Ombudsman being notified of those hospital transfers either. She reported the facility was previously only notifying the State Ombudsman if there was a discharge from the facility and they were not completing that notification for any hospital transfers.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, policy review and interview, the facility failed to ensure residents received nutritional interventions after weight loss was identified and failed to ensure residents were weighed as ordered. This affected four residents (#2, #6, #9 and #29) of four residents reviewed for nutrition. The census was 48.Findings Include:1. Medical record review revealed Resident #9 was admitted on [DATE] with diagnoses including dysphagia (oropharyngeal phase), schizophrenia, diabetes mellitus and bipolar disorder. Review of the Individual Nutrition Recommendations/Response dated 05/15/25 revealed the physician agreed with a dietitian recommendation to add weekly weights for four weeks. Review of the record revealed no evidence weekly weights were obtained as ordered. Review of the Nutritional Narrative Note dated 06/13/25 revealed Resident #9 recently went to hospital with slurred speech and low blood pressure. Symptoms were likely secondary to not wearing oxygen and a buildup of carbon monoxide and low blood pressures. The resident current diet order was a regular diet with dysphagia mechanical soft texture. Meal intakes were variable and poor. The resident was noted to have a significant weight loss of 7.5%. The resident met criteria for protein calorie malnutrition related to weight loss, decreased intakes and muscle wasting and the dietitian recommended to increase med pass (nutritional supplement) to four ounces three times a day and monitor her weight. Review of the electronic Physician Orders dated 06/15/25 revealed Resident #9's med pass was increased to three times daily and on 06/23/25 ice cream was ordered to be added to the lunch tray. There was no documentation of the amount of ice cream administered or consumed. Review of the Individual Nutrition Recommendations/Response dated 06/20/25 revealed Resident #9's physician agreed with recommendations to add ice cream to the lunch tray and she was appropriate for an appetite stimulant due to poor appetite. Review of the medical record revealed no evidence an appetite stimulant was initiated or ordered. Review of the electronic Medication Administration Record (e-MAR) dated June 2025 and July 2025 revealed Resident #9's med pass order did not include the amount to be administered and there was no documentation of how much med pass was accepted by the resident when administered. Review of the annual Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #9 was moderately impaired for daily decision-making, received a therapeutic and mechanically altered diet, required supervision/touch assistance with eating, was 64 inches tall, weighed 142 pounds(#) and had an unplanned significant weight loss. Review of the e-MAR dated August 2025 revealed Resident #9's med pass order did not include the amount to be administered and there was no documentation of how much med pass was accepted by the resident when administered between 08/01/25 through 08/24/25. On 09/02/25 between 12:07 P.M. and 12:21 P.M., observation revealed Resident #9 was not served ice cream with her lunch meal. Review of the Weights revealed Resident #9 weighed 144 pounds on 09/04/25. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/04/25 at 4:10 P.M., interview with the Director of Nursing verified there was no documented evidence of nutritional supplement/intervention for Resident #9 regarding amounts offered or consumed. On 09/11/25 between 10:29 A.M. and 10:47 A.M., phone interview with Registered Dietitian (RD) #203 revealed the facility was keeping her informed about Resident #9's weights and status until sometime around July/August 2025. It was then that she noticed a breakdown in the communication between her and the nursing department. RD #203 stated it was her expectation to have the amount of nutritional supplements ordered and documented, as she needed this information to accurately assess the residents' nutritional needs and status. RD #203 stated she has brought this up to the nursing department prior to this survey. Review of the policy: Nutritional assessment dated [DATE] revealed as part of the comprehensive assessment, the nutritional assessment will be a systematic multidisciplinary process that includes gathering and interpreting data and using that data to help define meaningful interventions for the resident at risk for or with impaired nutrition. 2. Review of Resident #29's medical record revealed she was admitted to the facility on [DATE]. His diagnoses included cerebral vascular accident (CVA)/ stroke with hemiplegia and hemiparesis affecting his left non-dominant side, adult hypertrophic pyloric stenosis, congestive heart failure (CHF), hypertensive heart and chronic kidney disease with heart failure, moderate protein calorie malnutrition, atherosclerosis, ischemic cardiomyopathy, depression, adult failure to thrive (, AFTT), iron deficiency anemia, and mixed hyperlipidemia. Review of Resident #29's quarterly MDS assessment completed on 08/18/25 revealed the resident did not have any communication issues and was cognitively intact. He was not known to have any mood indicators and was not known to display any behaviors during the assessment reference period (08/12/25- 08/18/25). He required set up or clean up assistance with eating. His height was 68 inches and his weight was 164 pounds. He was indicated to have had a significant weight loss and not on a physician prescribed weight loss program. Review of Resident #29's active care plans revealed he had a care plan in place for being a potential risk of nutritional decline related to the need for mechanically altered diet and medical diagnoses. He was known to have a history of significant weight changes and supplement use. He was identified as having had a significant weight loss on 06/20/25 and on 07/28/25. The goal was for the resident to maintain his weight with no significant changes. The interventions included providing supplements as recommended by the registered dietitian and as ordered by the physician. Review of Resident #29's weights revealed he had a significant weight loss between 06/13/25 and 07/08/25 when his weight went from 179.2 pounds to 160.7 pounds. He continued to have a significant weight loss between 07/08/25 and 07/28/25 when his weight went from 160.7 pounds to 156.4 pounds. His weight did stabilize, after his weight loss on 07/28/25, and trended upward when he weighed 164 pounds on 08/06/25. Review of Resident #29's progress notes revealed a nutrition note dated 06/20/25 at 11:55 A.M. that indicated the resident weighed 162.6 pounds on 06/16/25 representing a significant weight loss of more than 5% when compared to the resident's weight of 179.2 pounds, which was a 9.3% or / 16.6 pound weight loss. He was indicated to be on Med Pass supplement 4 ounces (oz) every day with good acceptance. The dietitian recommended increasing the Med Pass supplement to 4 oz twice a (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	day. Review of a nurses' progress note dated 06/23/25 at 11:13 A.M. revealed Resident #29 was in the hospital on that date. Dietary recommendations had been received via email and recommended the resident's Med Pass supplement to be increased to twice a day as was previously mentioned in the progress note dated 06/20/25. The physician was made aware and the increase in the resident's Med Pass supplement to 4 oz twice a day was to be implemented upon Resident #29's return from the hospital. Further review of Resident #29's progress notes revealed a nurse's note dated 06/27/25 that indicated the resident returned to the facility from the hospital. He arrived back at the facility at 2:30 P.M. Review of a nutrition review completed following Resident #29's re-admission to the facility revealed the resident's last available weight was 162.2 pounds. He was positive for a significant weight loss and the dietitian referred to the weight note dated 06/20/25. Med Pass supplement every day was indicated to be in place with good acceptance. He had a diagnosis of moderate protein-calorie malnutrition and continued to meet criteria related to weight loss and decreased intakes. The dietitian again recommended the Med Pass Supplement to be increased to 120 ml (4 oz) twice a day. Review of a nurse's note dated 07/09/25 at 8:30 A.M. revealed Resident #29's Med Pass was to be increased to two times a day for supplement per dietary recommendations. The physician was agreeable with the recommendation. Review of Resident #29's physician's orders revealed the resident's Med Pass supplement was ordered to be given twice daily. The order was received as a verbal order on 07/09/25 at 6:48 A.M. (12 days after it should have been implemented after the resident's re-admission from the hospital as previously ordered). Review of Resident #29's medication administration record (MAR) for July 2025 revealed the resident continued to receive Med Pass supplement once daily through 07/09/25. It was confirmed the Med Pass supplement was not increased to 4 oz twice a day until 07/09/25 (despite the increase that was supposed to be implemented upon his return from the hospital that occurred on 06/27/25). On 09/04/25 at 8:00 A.M., findings were verified by the Director of Nursing (DON) that Resident #29's recommended/ ordered increase in Med Pass 2.0 supplement from 4 ounces every day to 4 ounces twice a day that was recommended by the dietician on 06/20/25 and ordered by the physician on 06/23/25 was not implemented upon the resident's return from the hospital on [DATE]. She further confirmed that it was not until the dietitian saw the resident on 07/03/25, as a readmission review, that she recommended the increase again before the increase was finally started on 07/09/25. 3. Review of Resident #6's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included adult failure to thrive (AFTT), anemia in other chronic diseases, dysphagia (difficulty chewing), major depressive disorder, adult onset diabetes mellitus, malignant neoplasm of the colon, congestive heart failure, paraplegia, and unspecified protein-calorie malnutrition. Review of Resident #6's Medicare (MCR) 5 day Minimum Data Set (MDS) assessment revealed the resident did not have any communication issues and was cognitively intact. She was not known to display any behaviors and was not indicated to have refused any care. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #6's active care plans revealed she had a care plan in place for being at potential risk of nutritional decline related to morbidly obese status and medical diagnoses that included chronic kidney disease with dialysis, adult-onset diabetes mellitus, use of a therapeutic diet, significant weight loss, and supplement use. She had a history of refusing supplements and a significant weight loss was noted on 07/31/25 and 08/15/25. The goal was for the resident to maintain her weight with no significant changes. The interventions included providing supplements per the registered dietitian's recommendation and the physician's order. Review of a nurses' progress notes revealed a nurse's note dated 08/22/25 at 12:18 P.M. revealed the nurse notified the nurse practitioner (NP) about Resident #6's weight loss and poor eating habits. The NP spoke to the resident and gave new orders for the dietitian to evaluate and recommend supplements that the resident would take such as a Magic Cup (frozen nutritional treat) of a super donut. Review of a nutritional review note dated 08/23/25 at 4:45 P.M. revealed the dietitian evaluated Resident #6 as requested by the NP. The resident's current body weight at the time was 171.8 pounds which reflected a significant weight loss at one month, three months, and six months. Her weight back on 03/03/25 was 229.2 pounds reflecting a 25% or 57.4 pound loss in the past six months. Her weight on 07/24/25 was 182.8 pounds reflecting a 6% or 11 pound loss in the past month. The resident was indicated to be receiving Boost Breeze and Active as supplements with the Boost Breeze being given once a day and the Active being given twice a day. Due to her ongoing weight loss, it was recommended that they added a supplement, with the dietitian recommending a frozen nutritional supplement once daily. Review of Resident #6's physician's orders revealed the frozen nutritional treat was not ordered until 08/29/25. It was to be started on 08/30/25. Review of Resident #6's MAR for September 2025 revealed the nurses were initialing to show the resident had been receiving her frozen nutritional treat as ordered since 08/30/25. She was documented as having only taken 50% of the supplement in the first eight days of the month. On 09/08/25 at 7:45 A.M., an interview with Certified Nurse Aide (CNA) #146 revealed she was not aware of any supplements Resident #6 was on. She indicated any supplement given to the resident would be provided by the nurses. She was asked if that included any snacks or supplements provided by the dietary department. She claimed the nurses were the ones who also passed those snacks/ supplements that came from the kitchen. On 09/08/25 at 10:45 A.M., an interview with licensed practical nurse (LPN) #115 revealed Resident #6 was receiving supplements to include Boost Breeze and Active. She reported the resident often refused her Boost Breeze when offered, and would refuse the Active every time. Both supplements were given during the medication pass. She did not mention a frozen nutritional treat as one of the supplements the resident was supposed to receive. She reported the nurses gave most of the supplements, such as the Med Pass supplement, Boost, and Active. Some things such as snacks and certain snack-type supplements (such as frozen nutritional treats) were sent out by the kitchen on trays to be passed. She described the resident's appetite as being poor. She confirmed the resident had appeared as she lost weight, but she was not sure the exact amount of weight loss the resident had based on any numbers. On 09/08/25 at 2:10 P.M., an observation of the 2:00 P.M. snack/ supplement pass was completed to (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marietta Heights Post Acute	5001 State Route 60 Marietta, OH 45750

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	determine if Resident #6 was receiving her frozen nutritional treat at 2:00 P.M. as ordered. The tray sent from the kitchen to the nurses' station that was sitting on the counter at the nurses' station included three frozen nutritional treats that were marked for two residents residing in room [ROOM NUMBER] and one resident residing in room [ROOM NUMBER]. There was no frozen nutritional treat that had been sent out for Resident #6. On 09/08/25 at 2:40 P.M., a visit to the kitchen was completed to determine if they had a list they followed to determine which residents were to be given supplements from the kitchen and at what times. Dietary Director #148 provided a Order Listing Report dated 07/17/25 that had been printed at 1:32 P.M. Resident #6 was not in that list as being one of the residents receiving a snack or supplement from the kitchen. The order listing report had revisions made to it by hand written entries added and also included instructions at the top that read Don't Throw Away. On 09/08/25 at 2:43 P.M an interview with Dietary Aide #159 confirmed the order listing report provided by Dietary Director #148 was the list the dietary staff followed to know what residents needed snacks/ supplements from the kitchen and at what time. She denied knowledge of Resident #6 having an order to receive a frozen nutritional treat at 2:00 P.M. She named off the three residents that were provided frozen nutritional treats from the kitchen at 2:00 P.M. and it did not include Resident #6. She stated, if Resident #6 was supposed to get one, no one told her. On 09/08/25 at 2:46 P.M., a follow up interview with Dietary Director #148 confirmed Resident #6 was not included on the order listing report that the dietary staff used to determine who needed snacks/ supplements provided by the kitchen. She acknowledged Resident #6 had an order to receive a frozen nutritional treat daily at 2:00 P.M. since 08/30/25, in response to ongoing weight loss, and had not been receiving them. She was not able to explain why the order for the frozen nutritional treat did not get communicated to the kitchen. On 09/08/25 at 4:53 P.M., a follow up interview with LPN #115 confirmed she had not ever given Resident #6 a frozen nutritional treat sent from the kitchen for the 2:00 P.M. snack/ supplement pass. She was not aware the frozen nutritional treat had been ordered for the resident since 08/30/25. She commented the resident was likely not to take it as she was known to refuse other supplements they offered. 4. Record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including type II diabetes, mild intellectual disabilities, and anxiety disorder. Review of a physician order dated 01/03/25 revealed Resident #2 was to be weighed weekly for four weeks, then monthly. Review of a care plan initiated 06/26/24 and revised on 08/08/25 revealed Resident #2 was at potential risk of nutritional decline related to advanced age and medical diagnoses of chronic obstructive pulmonary disease, heart disease, type II diabetes, anemia, rheumatoid arthritis, hypomagnesemia, hyperlipidemia, ulcerative colitis, polyneuropathy, coronary artery disease, hypokalemia, atrial fibrillation, anxiety, dysphagia, gastroesophageal reflux disease, dementia, osteoarthritis, uterine cancer, myocardial infarction, transient ischemic attack, stroke, and food allergies including strawberries and tomatoes. Resident #2 had a significant weight loss, used supplements, and required honey-thickened liquids. Review of weights for Resident #2 revealed a weight was not completed in 08/2025 per orders for (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	monthly weights. Interview on 09/08/25 at 10:34 A.M. with Director of Nursing (DON) confirmed Resident #2 was not weighed in 08/2025 per physician orders. Review of a policy titled Weight Assessment and Intervention dated 03/2022 revealed residents are weighed upon admission and at intervals established by the interdisciplinary team and recorded in the medical record.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure residents were aware of the risks versus benefits of the use of psychotropic medications. This affected one resident (#2) of five residents reviewed for unnecessary medication. Findings Include:Record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including type II diabetes, mild intellectual disabilities, and anxiety disorder. Review of a care plan dated 06/26/25 and revised on 05/07/25 revealed Resident #2 required the used of psychotropic medications with potential for adverse reactions related to anxiety. Review of a minimum data set (MDS) dated [DATE] revealed Resident #2 had moderately impaired cognition and no behaviors. A physician order dated 05/19/25 revealed Resident #2 was receiving anti-anxiety medications and should be monitored for drowsiness, slurred speech, dizziness, nausea, and aggressive/impulsive behaviors every shift. Review of a physician order dated 05/23/25 revealed Resident #2 was receiving buspirone oral tablet 10 milligrams and to give two tablets by mouth every morning and at bedtime for dementia with agitation. Review of the medical record revealed no evidence of Resident #2 or her representative being made aware of risks versus benefits of psychotropic medications (buspirone) or consents for Resident #2 to receive the medication. Interview on 09/09/25 at 12:45 P.M. with Regional Support Nurse #168 confirmed there was no evidence of consent and education for Resident #2 to receive psychotropic medications. Review of a policy titled Psychotropic Medication Use dated 07/2022 revealed residents and/or representative have the right to decline treatment with psychotropic medications, the staff and physician will review with the resident/representative the risks related to not taking the medication as well as appropriate alternatives.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review and interview, the facility failed to maintain a safe and comfortable living environment. This affected one resident (#12) of 16 sampled residents. The census was 48. Findings include:Medical record review revealed Resident #12 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus, heart failure, anxiety disorder and osteoporosis. Review of the annual Minimum Data Set assessment dated [DATE] revealed the resident was moderately impaired for daily decision-making, utilized a wheelchair and walker for mobility, required supervision/touch assistance with toilet transfers, and was frequently incontinent of bowel/bladder. On 09/02/25 at 9:52 A.M., observation revealed Resident #12's bathroom toilet was positioned across from the bathroom door. Observation of the floor at the base of the toilet revealed the caulking was positioned away from the front and left sides of the toilet. On 09/02/25 at 10:55 A.M., interview with Resident #12 stated she uses her bathroom but did not know what had happened to the toilet. Resident #12 stated she does use the toilet in her bathroom. On 09/04/25 at 9:54 A.M., observation with Maintenance Director #108 of Resident #12's bathroom revealed the bathroom door was closed. Upon opening the door, the toilet base was sitting crooked and the caulking was observed not to be attached around the base of the toilet. There was a sewer odor in the bathroom at the time of the observation. Maintenance Director #108 verified the toilet was not secured and Maintenance Director #108 was observed moving the toilet base back and forth with his foot stating they should not have caulked the toilet as it was not secured to the floor which was allowing the sewer gas to escape into the bathroom. Maintenance Director #108 stated he was not aware of this concern, did not know who tried caulking around the toilet and verified the above at the time of the observation.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, preadmission screening and resident review (PASRR) review and interview, the facility failed to ensure PASRR level II screenings were completed as determined by resident needs and determinations by the state level II program were available for review. This affected one resident (#9) reviewed for PASSR. The census was 48. Findings Include:Medical record review revealed Resident #9 was admitted on [DATE] with diagnoses including bipolar disorder, schizophrenia and depression. Review of the significant change in condition PASRR dated 07/28/23 revealed Resident #9 had a decline. Diagnoses included paranoid schizophrenia, bipolar disorder, insomnia and other psychotic disorder. The resident had no functional limitations due to the mental disorder and had not been prescribed psychotropic medications in the previous six months. The facility was unable to provide screening results as to the determination by the state level II PASRR. Review of the electronic Physician Orders dated June/July 2025 revealed Resident #9 received the following medications: haloperidol (antipsychotic) 2 milligrams (mg) daily for schizophrenia, risperdal (antipsychotic) 4 (mg) daily for schizophrenia and venlafaxine ER 150 (mg) daily for depression. Review of the electronic Medication Administration Record (eMAR) between 06/27/25 and 07/01/25 revealed the following documented behaviors: Resident #9 refused medications on 06/27/25, 06/28/25 and 06/29/25. Resident #9 exhibited behaviors of anger and/or withdrawn/depressed on 06/27/25, 06/30/25 and 07/01/25. Review of the annual Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #9 was moderately impaired for daily decision-making and was not considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. The resident required supervision/touch assistance with eating, personal hygiene and toilet transfers, was frequently incontinent of bladder without a toileting program, had a weight loss and was not on a prescribed weight loss plan and received antipsychotic medications on a routine basis. The comprehensive assessment was documented as having no mood indicators or rejection of care; however, this was inaccurate as indicators were documented on the eMAR during the assessment reference dates. This inaccuracy was verified by Registered Nurse (RN) #144 on 09/04/25 at 3:55 P.M. On 09/08/25 at 9:58 A.M. interview with Operational Support #164 stated the PASRR completed 07/28/23 was the last PASRR submitted for review for Resident #9. At 10:56 A.M. interview with PACS Support verified there was no additional PASRR or result available for review. States will look to see if there was a procedure for review. On 09/08/25 at 10:56 A.M., interview with Operational Support #164 verified there was no additional information or results available for review and determination for the need of specialized services for Resident #9 from the screening dated 07/28/23. Operational Support #164 also verified there had been no new level II screening submitted related to changes noted during the annual MDS assessment on 07/03/25 including documented behaviors, receiving routine antipsychotic medications, activities of daily living needs and decline in bladder continence.

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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 and interview, the facility failed to ensure comprehensive care plans were developed as required. This affected three residents (Residents #2, #4 and #7) of 15 residents reviewed for care plans. The census was 48. Findings Include:1.Medical record review revealed Resident #4 was admitted on [DATE] with diagnoses including metabolic encephalopathy, hypertension, gastroesophageal reflux, benign prostatic hyperplasia, insomnia, osteoarthritis, history of fractures and constipation. Review of the electronic Physician Orders dated August and September 2025 revealed Resident #4 received the following medications: baclofen (muscle spasms) 10 milligrams (mg) as needed for hiccups, cholecalciferol (Vitamin D supplement) 50,000 units weekly, cyanocobalamin (Vitamin B-12 supplement) 1000 mcg/mL injection monthly, losartan potassium (hypertension) 50 (mg) daily, magnesium hydroxide 30 milliliters (ml) daily as needed for constipation, mirtazapine (antidepressant) 15 (mg) at bedtime for difficulty sleeping, aluminum-magnesium-Simethicone Suspension (maalox) 200-200- 20 MG/SML four times a day for gastro-esophageal reflux disease (GERD), protonix (proton pump inhibitor) 40 (mg) for GERD, tamsulosin (alpha-1 blocker) 0.4 (mg) daily for benign prostatic hyperplasia (BPH) and gualFENesln (expectorant) 400 (mg) twice a day for decongestant. Review of the electronic Medication Administration Record (MAR) dated August 2025 revealed Resident #4 had received the following medications: baclofen, tamsulosin, cholecalciferol, cyanocobalamin, losartan potassium, mirtazapine, maalox, protonix and guaifenesin. Review of the medical record revealed no comprehensive care plans for hypertension, constipation, hiccups, Vitamin-D and Vit-B deficiency, allergies, insomnia, GERD or BPH. On 09/10/25 at 10:22 A.M., interview with the Director of Nursing (DON) verified there was no evidence the above care plans were developed for Resident #4. 2.Record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including type II diabetes, mild intellectual disabilities, and anxiety disorder. Review of an order dated 11/26/24 revealed Resident #2 received hydrocodone-acetaminophen (opioid) oral tablet 5-325 mg one tablet by mouth every six hours for pain. Review of an order dated 01/07/25 revealed Resident #2 received insulin glargine 100 unit/ml solution pen inject 14 units subcutaneously two times a day for type II diabetes. Review of an order dated 02/11/25 revealed Resident received Aldactone (diuretic) oral tablet 25 mg one tablet a day for edema. Review of a minimum data set (MDS) dated [DATE] revealed Resident #2 received medications including but not limited to a diuretic, opioid, and a hypoglycemic (insulin). Review of a care plan dated 08/06/25 revealed no evidence of care plan for monitoring side effects for medications including insulin, diuretic, or an opioid. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/08/25 at 12:04 P.M. with Regional Registered Nurse #168 confirmed there were no care planned interventions for monitoring for side effects related to insulin, diuretic, or opioid. 3. Review of Resident #7's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included atrial fibrillation, malignant neoplasm of unspecified site of unspecified female breast, neoplasm of unspecified behavior or bone, soft tissue, and skin, and syncope and collapse. Review of Resident #7's physician's orders revealed the resident had an order that indicated the facility may need to administer oxygen at 2 liters per minute (LPM) to keep the resident's oxygen saturation level greater than 90% as needed (prn). The order originated on 07/29/25. Review of Resident #7's active care plans revealed the resident did not have a care plan in place to address her oxygen use. The active care plans were initiated on 03/28/25 and last revised on 04/12/25. A care plan addressing the resident's oxygen use was not added until 09/03/25, after it had been brought to the attention of the facility. Review of Resident #7's medication administration record (MAR's) and treatment administration record (TAR's) for August and September 2025 revealed the nurses were not documenting the use of oxygen for the resident. It was not included on either record indicating that it had been used. On 09/03/25 at 8:01 A.M., an observation of Resident #7 noted her to be sitting up in her bed with the head of bed elevated. She was noted to have oxygen on at 2 LPM per nasal cannula with no distress noted. Her respirations were easy and unlabored. On 09/03/25 at 8:28 A.M., an interview with the Director of Nursing (DON) confirmed Resident #7 had the use of oxygen. She further confirmed the resident's active care plans did not reflect she had the use of oxygen.

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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, and interview, the facility failed to ensure a resident, who was dependent on staff for personal care, was provided the assistance needed to complete bathing activities of her choice when scheduled, and nail care was provided when needed. This affected one (Resident #7) of four residents reviewed for activities of daily living (ADL's). The facility census was 48. Findings include: Review of Resident #7's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included rheumatoid arthritis, osteoarthritis, difficulty walking, and adult-onset diabetes mellitus. Review of Resident #7's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues. Her cognition was moderately impaired. She was not known to have displayed any behaviors or reject care during the seven day assessment period (06/20/25- 06/26/25). She required partial/ moderate assistance with showers/ bathing and required set up or clean-up assistance for personal hygiene. Review of Resident #7's active care plans revealed she had a care plan in place for the resident to be at risk for ADL/ mobility decline and required assistance related to limited mobility, rheumatoid arthritis, and polyarthritis. The care plan was initiated on 04/02/25. The goal was for the resident to have her needs anticipated and met by staff. The interventions included encouraging the resident to participate in ADL's to promote independence, provide hand hygiene and nail care per the resident's preference, and to provide showers and/ or bed baths per the resident's preference. There was nothing in her active care plans that indicated she was non-compliant or known to refuse personal care services to include bathing and nail care. Review of Resident #7's care record that was part of her electronic medical record (EMR) revealed the resident's shower days were Wednesdays and Saturdays. Her bathing activity was to occur on the day shift. Review of Resident #7's shower documentation under the task tab of the EMR revealed the resident's last documented shower was on 08/23/25. Nail care was indicated to have been provided on that date as part of her bathing activity. She was indicated to have refused her shower when offered on 08/27/25 (Wednesday). There was no indication of her being offered a shower/ bath on 08/30/25 (Saturday), which was the last day she was scheduled to receive one. On 09/02/2025 at 1:03 P.M, an observation of Resident #7 noted her to be lying in bed. She was noted to have a dark substance under her fingernails on some of her fingers. On at 09/03/2025 at 10:16 A.M., further observation of Resident #7 noted her to be in bed. Her fingernails continued to have a dark colored substance under the ends of her fingernails. An interview with the resident at the time of the observation revealed she did not recall staff offering her a shower on 08/30/25 (Saturday), the last day she was scheduled to receive one. On 09/03/25 at 10:19 A.M. an interview with RN #200 revealed all showers/ baths were documented in the computer. She denied the facility used any paper shower sheets for the documentation of showers. On 09/03/25 at 10:30 A.M., an interview with the Director of Nursing (DON) confirmed Resident #7's scheduled shower days were on Wednesdays and Saturdays and were to be completed on day shift. She verified the resident's last documented shower was provided on 08/23/25, in which nail care was provided. The resident was indicated to have refused her shower on 08/27/25, when offered. She further confirmed there was no documentation to support the resident had been offered or provided a shower on 08/30/25 (her most recent scheduled shower day). She acknowledged the resident had been observed yesterday and again today to have a dark colored substance under her fingernails. On 09/03/25 at 11:17 A.M., an interview with Certified Nursing Assistant (CNA) #146 revealed she was just in Resident #7's room and provided her a bed bath. She indicated the resident preferred bed baths, as opposed to showers. She was asked what she did as part of that bathing activity. She reported she washed the resident's hair and also did nail care. She confirmed the resident's fingernails were dirty underneath the end of the nails. She stated that was why she cleaned them. She denied she worked last Saturday to be able to say why there was no documentation of the resident being given her scheduled complete bed bath. She reported the (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was an extensive assist of one for bathing and personal hygiene care. She denied the resident was able to perform her own nail care and was dependent on the staff to do it. This deficiency represents non-compliance investigated under Complaint Intake Number 259304.

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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 observation, record review, and interview, the facility failed to ensure care planned interventions for turning and repositioning were completed to promote timely and adequate healing of a pressure ulcer for Resident #1 and failed to ensure newly identified skin breakdown was timely identified and treated. This affected one resident (#1) of two residents reviewed for wound care. The facility census was 48.Findings include: Record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including type II diabetes, muscle weakness, and acute kidney failure.Review of a care plan initiated on 03/20/24 (and last updated on 06/11/25) revealed Resident #1 had an alteration in skin integrity related to pressure, a Stage III (defined as full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present) to the sacrum, and a boil to left hip. A goal included demonstrating gradual healing as evidenced by decreased size and depth of wound by next review. Interventions included administer medications per physician orders; document wound status weekly and as needed, notify physician of signs and symptoms of infection, non-healing status, increased pain with wound care; encourage resident to wear Prevalon boots to bilateral feet at all times as tolerated; enhanced barrier precautions; low air loss mattress; monitor wound for signs or symptoms of infection such as foul odor, change in drainage consistency and type, increase in size of wound, redness, pain and edema; and treatments per order.Review of a care plan dated 03/31/24 (and revised on 04/02/25) revealed Resident #1 had the potential for alteration in skin integrity related to history of skin breakdown, immobility, incontinence, and use of neck pillow while in bed. Goals included not developing further skin breakdown through review date. Interventions included administer medications as ordered; administer treatments as ordered; apply moisturizing lotion as needed for dry skin; educate resident/family as to causes of skin breakdown including transfer/positioning requirements, importance of taking care during ambulating/mobility, good nutrition and frequent repositioning; low air loss mattress; offload heels as tolerated; pain assessment quarterly; pressure redistribution cushion to chair; Prevalon boots ; remove wet or soiled clothing, briefs, provide incontinent care, apply protective barrier after each incontinent episode, maintain resident dignity during incontinent care, skin assessment weekly, therapy per order; and turn and repositioning as needed.Review of an order dated 10/15/24 revealed Resident #1 received Juven (nutrition powder used for wound healing) two times a day for wound healing.Review of an order dated 04/26/25 revealed Resident #1 had a low air loss mattress to her bed.Review of an order from Physician #301 dated 06/19/25 revealed Resident #1 received wound care for Stage III pressure ulcer to sacrum, cleanse with inhouse wound cleanser and pat dry, apply hydrofera blue cover with foam dressing Monday, Wednesday, Friday, and as needed.Review of a Minimum Data Set (MDS) assessment completed 06/25/25 revealed Resident #1 had no behaviors, required maximum assistance for bed mobility, and had one Stage III pressure ulcer.Review of a wound care note dated 07/16/25 revealed Resident #1's Stage III pressure area was improving, measured 2 centimeters (cm) in length, 0.4 cm width, 0.2 cm in depth with an area of 0.8 cm squared and a volume of 0.16 cm cubed. The wound had a moderate amount of exudate, 100% granulation tissue, wound edges were distinct, full thickness to wound bed and a pink color to peri wound area.Review of a wound care note dated 07/30/25 revealed Resident #1's Stage III pressure area was unchanged, measured 2.1 cm in length, 0.3 cm in width, 0.2 cm in depth, 0.63 cm squared area and a volume of 0.13 cm cubed. The wound had a moderate amount of exudate, 100% granulation tissue, distinct wound edges, full thickness wound bed, and a pink hue to the peri wound area.Review of a wound care note dated 08/06/25 revealed Resident #1's Stage III pressure ulcer was unchanged, measured 2.3 cm in length, 0.3 cm in width, 0.2 cm in depth, 0.69 cm squared area and a volume of 0.14 cm cubed. The wound had moderate exudate, 100% granulation tissue, distinct edges, full thickness wound bed and a pink hue to peri wound area.Review of a wound note dated 08/13/25 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed Resident #1's Stage III pressure ulcer was unchanged, measured 2.3 cm in length, 0.3 cm in width, 0.2 cm in depth, 0.69 cm squared in area and a volume of 0.14 cm cubed. The wound had moderate exudate, 100% granulation tissue, distinct edges, and a pink hue to the peri wound area.Review of a wound care note dated 08/20/25 revealed Resident #1's Stage III pressure ulcer was improving with measurements of 2 cm length, 0.3 cm width, 0.2 cm depth, 0.6 cm squared area and volume of .12 cm cubed. The wound had moderate exudate, 100% granulation tissue, distinct edges, and a pink hue to the peri wound area.Review of a wound care note dated 08/27/25 revealed Resident #1's Stage III pressure ulcer was unchanged with a healing rate of -0.0070 millimeters a day, measured 2.5 cm in length, 0.4 cm in width, 0.2 cm in depth, 1 cm squared area and a volume of 0.2 cm cubed. The wound had moderate exudate, 100% granulation tissue, distinct wound edges, and a pink hue to the peri wound area.Review of task documentation revealed staff documented Resident #1 was turned and repositioned daily from 08/05/25 through 09/03/25.Observation on 09/03/25 at 9:04 A.M. revealed Resident #1 was resting in bed, lying on her back. Continuous observation on 09/03/25 from 9:28 A.M. to 10:23 A.M. revealed Resident #1 remained on her back with no evidence any staff entered her room during this time period. Continuous observations on 09/03/25 from 12:26 P.M. to 2:53 P.M. revealed Resident #1 was resting on her back. At 1:10 P.M., two nurses, Licensed Practical Nurse (LPN) #109 and #104 entered her room to provide wound care and exited the room at 1:20 P.M. Following the treatment, Resident #1 remained on her back. At 1:50 P.M., Certified Nursing Assistant (CNA) #153 entered Resident #1's room to provide a bed bath. At 2:19 P.M., another surveyor entered Resident #1's room to observe wound care with LPN #109. Once wound care was completed, the resident was positioned directly on her back. At 2:53 P.M. the resident remained on her back with no evidence of staff turning and repositioning the resident to reduce pressure to her sacral area. Observation of the resident's sacral wound care on 09/03/25 at 2:19 P.M. revealed the peri wound area was reddened to the resident's bilateral gluteal folds with a small open area with a red wound bed with no treatment in place to this area.Interview on 09/03/25 at 3:42 P.M. with CNA #153 revealed residents should be turned and repositioned every two hours. CNA #153 stated Resident #1 had pain in her hips and doesn't always like to have a pillow under her to relieve pressure. CNA #153 confirmed Resident #1 was positioned on her back at the time of this interview. CNA #153 stated she was unable to verify she had actually completed resident checks/rounds every two hours. Interview on 09/04/25 at 8:50 A.M. with Resident #1 revealed staff do not offer to turn or reposition her to help relieve pressure from her coccyx/sacral area.Interview on 09/04/25 at 8:57 P.M. with LPN #109 revealed Resident #1 did not refuse wound care treatments and there was no documented evidence the resident was non-compliant with care. LPN #109 confirmed staff were documenting Resident #1 was being turned and repositioned. However, LPN #109 stated she believed Resident #1 did have a tendency to want to lay on her back and not move due to chronic pain. LPN #109 stated pain medications were in place to assist. Interview on 09/04/25 at 10:40 A.M. with the Director of Nursing (DON) revealed she was unsure if there should be any type of barrier cream applied to the resident's peri wound area because she had not assessed the wound herself. The DON was informed of the previous wound care observation with additional skin impairment in the peri wound area of the Stage III pressure ulcer. Interview on 09/04/25 at 10:41 A.M. with LPN #104 confirmed Resident #1 did not have a barrier cream or treatment to reddened areas around the Stage III pressure wound.Review of an order from Physician #301 dated 09/04/25 at 11:41 A.M. revealed Resident #1 had a new order in place for moisturizing barrier cream after each incontinence episode.Observation of wound care on 09/08/25 at 2:26 P.M. revealed assessment of gluteal folds revealed dried skin area which LPN #104 confirmed. After wound care was completed, Resident #1 was positioned on her back in supine position. Interview on 09/09/25 at approximately 3:00 P.M. with Regional Registered Nurse (RN) #162 confirmed the above wound care measurements from 08/20/25 to 08/27/25 which noted the wound was slightly larger per the wound care notes. The observations of Resident #1 not being turned or repositioned to relieve pressure and interviews completed with staff regarding Resident #1's Stage III (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure ulcer were also shared with RN #162. Review of a manual for Pressure Guard mattress revealed the use of the mattress was only one element of care in the prevention and treatment of pressure ulcers. Frequent repositioning, proper care, routine skin assessments, wound treatment and proper nutrition were but a few other elements required in the prevention and treatment of pressure ulcers. As there were many factors that may influence the development of a pressure ulcer for each individual, the ultimate responsibility in the prevention and treatment of pressure ulcers was with the health care professional.Review of a policy titled Prevention of Pressure Injuries dated 04/2020 revealed prevention could include keeping the skin clean and hydrated, clean promptly after incontinence episodes, use a barrier product to protect skin from moisture, reducing friction, and protective dressings for at risk individuals. Reposition all residents with or at risk of pressure injuries on an individualized schedule, select appropriate support surfaces based on resident's needs, evaluate and report changes in the skin.

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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, interview, and record review the facility failed to ensure smoking aprons were worn during smoking time. This affected one resident (#49) of five residents observed during their smoking time. The census was 48.Findings include:Record review revealed Resident #49 was admitted [DATE] with diagnoses including cerebral infraction, aphasia, hemiplegia, lupus, stage three chronic kidney disease, hypertension, hyperlipidemia, gastro-esophageal reflux disease, muscle weakness, obesity, depression, apraxia, and anxiety.Review of quarterly minimum data set (MDS) completed 06/11/25 revealed a brief interview for mental status (BIMS) score of 13. Resident #49 had upper extremity impairment.Review of Resident #49's most recent quarterly smoking observation/ assessment completed 07/02/25 revealed the resident is a smoker, smokes cigarettes, the resident has dexterity impairment, the resident needed adaptive equipment of a smoking apron with supervision. Resident was observed to drop ashes and cigarette on self while smoking. Resident requires smoking apron for safety. Interdisciplinary team members involved include Director of Nursing (DON), MDS nurse, Social Services Director, and therapy.Review of Resident #49's care plan completed 07/14/25 revised on 09/02/25 revealed Resident #49 has potential for injury related to smoking due to poor safety awareness, Cerebrovascular accident (CVA). Goals include resident safety will be maintained every shift.Observation on 09/03/25 at 3:15 P.M. of Resident #49 in the designated smoking area actively smoking a cigarette with no apron on.Observation on 09/03/25 at 3:30 P.M. revealed Resident #49 in the designated smoking area actively smoking a cigarette with no apron on. At the time of the observation, interview with Receptionist #1002 confirmed Resident #49 does not have an apron on while smoking. Receptionist #1002 stated as of 09/02/25 Resident #49 does not wear a smoking apron anymore. Receptionist #1002 stated it's a lot for one person to round everyone up and get everyone situated and set up (for smoking).Review of the facility policy titled Smoking Policy (revised October of 2023) revealed a resident's smoking status is evaluated upon admission, including ability to smoke safely with or without supervision per a completed safe smoking evaluation. The staff consults with the attending physician and the director of nursing services to determine if safety restrictions need to be placed on a resident's smoking privileges based on the safe smoking evaluation.

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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, policy review and interview, the facility failed to ensure systems were in place to restore normal bladder function for Resident #9 and to prevent additional decline in urinary continence. This affected one resident (#9) of one sampled resident for bladder incontinence. The facility identified 22 residents with bladder incontinence. The census was 48. Findings Include: Medical record review revealed Resident #9 was admitted on [DATE] with diagnoses including bipolar disorder, schizophrenia and depression. Review of the quarterly Minimum Data Set 3.0 (MDS) assessments dated 01/04/25 and 04/05/25 revealed Resident #9 was moderately impaired for daily decision-making. The resident was independent in both toileting hygiene and toilet transfers during both assessments and was occasionally incontinent of urine without a retraining/toileting program. The resident was continent of bowel. The resident was receiving antipsychotic medications on a routine basis only. Review of the annual Nursing Bowel and Bladder Observation/Assessment - V 3.0 assessment dated [DATE] revealed the resident had bladder incontinence with urinary symptoms including stress and mixed incontinence. The resident was assessed to be continent of bowel. Review of the assessment revealed no evidence of a bladder tracking evaluation to identify a pattern. No toileting program was initiated or documented as being implemented or in place. Review of the annual Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #9 was moderately impaired for daily decision-making. The resident now required supervision/touch assistance with both toileting hygiene and toilet transfers and had declined to being frequently incontinent of urine without a toileting program. The resident was continent of bowel. The resident received antipsychotic medications on a routine basis only. Review of the annual History & Physical dated 07/11/25 completed by certified nurse practitioner (CNP) #201 revealed Resident #9's urinary incontinence was not addressed or identified. Review of the task: Bladder Continence dated 08/10/25 through 09/08/25 revealed Resident #9 was continent of urine 18 times and was incontinent of urine 41 times. Review of the task: Bowel Continence dated 08/10/25 through 09/08/25 revealed Resident #9 was incontinent of bowel once. Review of the Physician Orders dated September 2025 revealed no evidence of interventions to restore bladder function. Review of the care plan: Bladder Incontinence related to Medication Side Effects, Physiological Changes, Stress and Mixed incontinence initiated 04/22/2024. Interventions included to check the resident to see if he/she is continent, offer to assist with toileting. If he/she is incontinent, remove wet or soiled clothing, briefs; provide incontinent care; apply protective barrier after each incontinent episode; maintain resident dignity during incontinent care. Monitor for signs and symptoms of UTI (urinary tract infection: burning on urination, flank pain, hematuria, difficulty voiding, change in mental status, change in behavior, fever, change in color, clarity & odor of urine) and provide incontinence care after each episode. Check skin for breakdown and apply protective skin barrier cream and use verbal reminders for use of bathroom. No individualized interventions had been added to the plan of care since the plan was initiated. Review of the policy Urinary Continence and Incontinence - Assessment and Management (dated August 2022) revealed the staff and practitioner will appropriately screen for, and manage, individuals with urinary incontinence. Management of incontinence will follow relevant clinical guidelines. The physician and staff will provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections to the extent possible. As indicated and if the individual remains incontinent despite treating transient causes of incontinence, the staff will initiate a toileting plan. As appropriate, based on assessing the category and causes of incontinence, the staff will provide scheduled toileting, prompted voiding or other interventions to try to manage incontinence. Toileting programs will start with a 3- to 5-day toileting assistance trial. Incontinence care should be individualized at night in order to maintain comfort and skin integrity and minimize sleep disruption. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prompted voiding is not helpful at night and has been shown to disrupt sleep. On 09/02/25 between 12:07 P.M. and 12:21 P.M., observation of the meal delivery revealed Resident #9 was lying in bed with her body and head covered with a blanket. Her room lights were off, and the television was on. Staff woke the resident up, assisted her to a seated position on the side of the bed, set-up her meal tray, and left the resident's room without cueing the resident to go to the bathroom to void. On 09/04/25 at 12:14 P.M., observation revealed Registered Nurse (RN) #144 entered Resident #9's room with her lunch meal tray. Resident #9 was observed lying in bed with her eyes closed and was snoring. RN #144 set the resident's meal tray on the overbed table and began talking to the resident, touching her shoulder, stroking the resident's hair and rubbing her back while stating 'your lunch is here it is time to get up'. At 12:19 P.M., the resident began to arouse, and RN #144 assisted the resident to a seated position on the side of the bed. The resident's eyes remained closed as she was sitting at the bedside. RN #144 left the room and stated to Licensed Practical Nurse (LPN) #120 'she was sleeping so good, she didn't want to wake up'. RN #144 and LPN #120 did not cue Resident #9 to go to the bathroom and continued to pass medications and meal trays to other residents on the hallway. On 09/08/25 at 9:57 A.M., interview with the director of nursing (DON) stated that in June 2025 the resident had been hospitalized and upon return the resident did not want to get out of bed, required additional assist with eating and transfers, and went from taking herself to the toilet to having episodes of incontinence. Since the annual MDS assessment dated [DATE] the resident has snapped out of it and was no longer having a problem with incontinence. When the surveyor reviewed the resident's episodes of incontinence in the last 30-days with the DON, the DON agreed the resident's incontinence had not resolved or improved. The DON stated she was unaware of this and verified Resident #9 had not had any interventions implemented to restore bladder function since the noted decline (per the DON) upon return from the hospital around 06/12/25. On 09/08/25 at 1:00 P.M. interview with Registered Nurse (RN) #144 revealed there were no known bladder restorative programs currently at the facility. RN #144 stated when she identifies a decline in a resident's continence, she notifies the interdisciplinary team including the Director of Nursing (DON) and it was up to them to decide what was to be done. RN #144 stated she does not initiate any interventions to restore continence and does not have any bladder continence records during her assessments except the shift documentation. She does not have any review documentation during the assessment specific to dates or time of day when the resident was incontinent; therefore, she cannot individualize a program on the information she gathers. On 09/08/25 at 1:05 P.M. interview with RN #168 stated he was unable to pull a history report from the electronic documentation system indicating when the resident was incontinent. RN #168 stated the computer system only shows a shift, not the documentation in the task itself of when a resident was incontinent. RN #168 stated moving forward, the facility will be implementing a 3-day tracker to monitor incontinence in order to implement individualized interventions to restore bladder function. On 09/08/25 at 1:37 P.M. interview with Resident #9 stated she has some control of her bladder and could not state a specific time that she was incontinent but knows she has to void especially when she first wakes up. Resident states she can walk to the bathroom but does have incontinence episodes. Resident #9 stated she would be agreeable to try something to help reduce her urinary incontinence. On 09/09/25 at 1:25 P.M., interview with the DON stated there were no bladder retraining or restorative programs currently in the facility. On 09/09/25 at 3:07 P.M., interview with LPN#104 stated Resident #9 was incontinent of bladder and there were no residents that she was aware of currently on a retraining bladder program. Residents are checked and if incontinent, care is provided. If a resident would need a program, she would notify RN #144. On 09/09/25 at 3:10 P.M., interview with Director of Rehabilitation #121 stated there has been no formal restorative nursing programs for at least a year. Director of Rehabilitation #121 stated if a resident started having incontinence issues due to a decline in ADL's (e.g. transfers or ambulation), that would be something that the therapy department could screen to see if appropriate for therapy services. All residents were screened quarterly and if they receive therapy (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	services, they could be discharged , if appropriate, to receive a functional maintenance program. Director of Rehabilitation #121 stated she had not been informed of any ADL concerns in regard to Resident #9.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and policy review, the facility failed to ensure pharmacy recommendations were addressed in a timely manner and contained a rationale for decision. This affected two (#2 and #49) of five residents reviewed for unnecessary medications. The facility census was 48. Findings include: 1.Record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including type II diabetes, mild intellectual disabilities, and anxiety disorder. Review of a document titled Gradual Dose Reduction (GDR) Recommendation dated 04/25/25 revealed a recommendation to reduce buspirone (anti-anxiety) and duloxetine (antidepressant). The physician declined the recommendation and stated see psych notes. Review of a care plan initiated on 06/26/24 and revised on 05/07/25 revealed Resident #2 required the use of psychotropic medications with potential for adverse reactions related to anxiety. Interventions included but were not limited to evaluate the effectiveness and side effects of medications for possible decrease/elimination of psychotropic drugs. Review of a minimum data set (MDS) dated [DATE] revealed Resident #2 had no behaviors and had received anti-anxiety and antidepressant medications. Review of a behavioral health note dated 05/09/25 revealed Resident #2 may have anxiety concerns but at the time of the assessment was calm and appropriately behaved. Buspirone was increased from 10 milligrams (mg) two times per day to 15 mg two times per day. Review of a behavioral health note dated 05/23/25 revealed Resident #2 no longer needed duloxetine 20 mg per day and the medication was discontinued. Interview on 09/08/25 at 1:57 P.M. with Regional Registered Nurse #168 revealed pharmacy recommendations should be reviewed within 14 days the recommendation is made and confirmed Resident #2's discontinuation of duloxetine was not addressed within 14 days. Review of a policy titled Psychotropic Medication Use dated 07/2022 revealed residents on psychotropic medications receive gradual dose reductions coupled with non-pharmacological interventions unless clinically contraindicated in an effect to discontinue these medications. 2. Record review revealed Resident #49 was admitted [DATE] with diagnoses including cerebral infraction, aphasia, hemiplegia, lupus, stage three chronic kidney disease, hypertension, hyperlipidemia, gastro-esophageal reflux disease, muscle weakness, obesity, depression, apraxia, and anxiety. Review of quarterly minimum data set (MDS) completed 06/11/25 revealed a brief interview for mental status (BIMS) score of 13. Resident #49 had a total severity score of 0 for mood. Resident #49 had no displayed behaviors. Section M for medications revealed Resident #49 is on an antianxiety, antidepressant, and hypnotic. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed an order dated 02/18/25 for Ativan 0.5 milligram (mg) give two tablets by mouth (PO) twice a day (BID) for anxiety. Record review revealed a Pharmacy recommendation on 07/30/35 with Pharmacist recommendation stated Resident #49 is receiving Ativan 0.5 mg PO BID for anxiety. Recommendation stated CMS guidelines require periodic gradual dosage reduction (GDR) attempts for all psychotropics, or a detailed physician progress note to support their continues use. If warranted suggest a GDR of Ativan 0.5mg PO once daily for anxiety. Physician disagreed with no rationale on 07/31/25. Interview on 09/04/25 at 1:20 P.M. with Assistant Clinical Regional Director #167 confirmed the pharmacy recommendation for Resident #49 on 07/30/25 regarding Ativan did not have a rationale from the physician for the disagreement of the recommendation by the pharmacist regarding Ativan.

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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 medical record review, policy review and interview, the facility failed to ensure opioid pain medications had adequate monitoring including indications of when to administer. This affected one resident (#4) of five residents reviewed for unnecessary medications. The census was 48. Findings Include: Medical record review revealed Resident #411/14/22 was admitted on [DATE] with diagnoses including metabolic encephalopathy, hypertension, gastroesophageal reflux, benign prostatic hyperplasia, insomnia, osteoarthritis, history of fractures and constipation. The resident was admitted to hospice services on 07/19/25. Review of the care plan: Risk for Pain/Discomfort related to arthritis, depression, hip fracture and neuralgia initiated 04/03/24 and revised on 03/10/25 included the following interventions: administer pain medications as ordered by the physician. Assess for pain and if experiencing pain, rate the pain per [NAME]-BAKER faces pain scale. Document, report complaints and non-verbal signs of pain. Review of the 5-day/Significant Change in Condition Minimum Data Set assessment dated [DATE] revealed Resident #4 was severely impaired for daily decision-making, was not receiving scheduled or PRN (as needed) pain medications, and denied pain at the time of the assessment. Review of the electronic Physician Orders dated June through August 2025 revealed the following medications were Review of the Order Summary Report dated 09/03/25 revealed the following orders to manage Resident #4's pain: Tylenol 325 milligrams (mg) two tablets every six hours as needed (PRN) for pain (ordered 05/11/25), aspirin 81 (mg) daily for pain (ordered 07/19/25), hydrocodone acetaminophen 5/325 (mg) every four hours PRN for pain (ordered 05/11/25) and morphine sulfate (MSO4) 20 mg/milliliter (mL) give 0.5 (mL) every four hours PRN for pain/shortness of breath (ordered 07/21/25). Further review of Resident #4's Physician Orders revealed no evidence of physician parameters of when to administer: Tylenol versus hydrocodone versus MSO4. Review of the electronic Medication Administration Records dated June 2025 through August 2025 revealed the following medications were administered for pain: a. On 06/23/25 at 8:02 P.M., pain rated a six out of 10 and was administered one hydrocodone-acetaminophen (Norco) 5-325 mg. b. On 06/27/25 at 7:10 A.M., pain rated a six out of 10 and was administered one Norco 5-325 mg. c. On 07/15/25 at 7:47 A.M., pain rated a seven out of 10 and was administered one Norco 5-325 mg.d. On 07/15/25 at 11:47 A.M. and 5:58 P.M., pain rated a six out of 10 and was administered one Norco 5-325 mg. e. On 07/19/25 at 2:00 P.M., pain rated a five out of 10 and was administered one Norco 5-325 mg. f. Between 08/01/25 and 08/31/25, aspirin 81 mg was administered daily for pain.g. On 08/06/25 at 10:29 A.M., 2:00 P.M. and 7:00 P.M., pain was rated a six and was administered one Norco 5-325 mg. h. On 08/07/25 at 9:13 A.M., pain rated a six out of 10 and was administered one Norco 5-325 mg. i. On 08/07/25 at 1:13 P.M. and 5:13 P.M., pain rated a five out of 10 and was administered one Norco 5-325 mg. On 09/04/25 at 6:55 A.M., interview with Licensed Practical Nurse (LPN) #126 stated residents were assessed for signs and symptoms of pain and administered medications as ordered. LPN #126 stated when a resident complained of pain depending on the rated pain, she would look to see what medication was ordered and administer it. LPN #126 stated she used her best judgement on determining what medication to administer if there were multiple ones ordered to choose from. On 09/08/25 at 10:13 A.M., interview with the Director of Nursing (DON) verified there were no parameters for when the nurse should administer Tylenol versus oxycodone versus morphine sulfate. The DON stated the nurse was determining which medication to given for pain scale using a non-verbal scale and her interpretation may be different than another nurse. Review of the policy: Pain-Clinical Protocol revised March 2018 revealed the physician and staff will identify the characteristics of pain and use a consistent approach. Periodically the physician will evaluate and summarize the status of an individual with chronic or fluctuating pain including the status of any active conditions that exacerbate pain and effectiveness of current interventions for pain. If pain is stable and the underlying cause is resolved or it is unclear whether a source of pain remains, the (continued on next page)

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	365780	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marietta Heights Post Acute	5001 State Route 60 Marietta, OH 45750

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician will consider a trial reduction or elimination of analgesic medications. Reductions in opioid analgesics are especially important in light of their limited efficacy in the treatment of chronic non-cancer pain and their many diverse significant side effects. It should not just be assumed that the absence of pain symptoms implies the need for indefinite analgesic administration. Sometimes a trial tapering or discontinuation of analgesics is indicated to determine if current medications or doses are still needed.

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F 0760 Level of Harm - Minimal harm or potential for 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 medical record review, policy review and interview, the facility failed to prevent a significant medication error involving Resident #4 when the resident was not administered an antibiotic as ordered to treat aspiration pneumonia. This affected one resident (#4) of five residents sampled for unnecessary medications. The census was 48. Findings Include:Medical record review revealed Resident #4 was admitted on [DATE] with diagnoses including metabolic encephalopathy, dysphagia, pharyngeal phase, Barrett's esophagus without dysplasia and diaphragmatic hernia without obstruction or gangrene. Review of the Significant Change in Status assessment/5-day MDS assessment dated [DATE] revealed Resident #4 was severely impaired for daily decision-making and was receiving an antibiotic. Review of the electronic Physician Orders dated July 2025 revealed to administer cefpodoxime (antibiotic) 200 milligrams every 12 hours via PEG tube for aspiration pneumonia. Review of the electronic Medication Administration Record dated July 2025 revealed Resident #4 was ordered to received the first dose of cefpodoxime on the morning of 07/19/25; however, it was not available to be administered. Further review revealed only nine of the 10 ordered doses were administered between 07/19/25 and 07/23/25. On 09/08/25 at 12:04 P.M., interview with Registered Nurse #168 verified Resident #4 did not receive all 10 ordered doses of cefpodoxime 200 mg between 07/19/25 and 07/23/25. Review of the policy: Administering Medications revised April 2019 revealed medications were to be administered in a safe and timely manner, and as prescribed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and policy review the facility failed to ensure medications were stored and labeled properly. This had the potential to affect two residents (#2, #23) of three residents observed for medication pass and four medication carts with one medication room observed for medication storage and labeling.Findings include:. Record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, type II diabetes, Chronic Obstructive Pulmonary Disease (COPD), rheumatoid arthritis, cognitive communication deficit, resp failure with hypoxia, muscle weakness, ulcerative colitis, transient ischemic attack (TIA), moderate protein-calorie malnutrition, atrial fibrillation, mild intellectual disabilities, dysphagia, syncope and collapse, cerebral infarction, hypertension, bell's palsy, dementia, anemia, gout, hyperlipidemia, hypokalemia, atherosclerotic heart disease without angina, hypertensive heart disease with heart failure, Gastro-esophageal reflux disease. and anxiety.Record review of Resident #2's quarterly minimum data set (MDS) completed on [DATE] revealed a brief interview for mental status (BIMS) score of nine indicating cognitive impairment.Record review of Resident #2's quarterly MDS completed [DATE] for section N- medications revealed the resident was taking a hypoglycemic medication and the resident had received seven insulin injections in the last seven days.Record review for Resident #2's orders revealed an order for Basaglar kwikPen solution pen-injector 100 unit/ML (Insulin Glargine) to inject 17 units subcutaneously two times a day for diabetes mellitus.Observation on [DATE] at 8:56 A.M. of medication cart on hall 200 revealed a 10 ML insulin injection pen brand Semglee labeled opened [DATE] and a insulin injection pen brand Basglar labeled opened [DATE] in the top drawer of the medication cart labeled with Resident #2's name.At the time of the observation, interview with Licensed Practical Nurse(LPN) #115 confirmed Insulin injection pen Semglee and Insulin injection pen Basglar were expired as they were opened over 28 days ago and were still in the top drawer of the medication cart on 200 hall.Review of medication insert for Semglee 10 ML insulin injection pen revealed Semglee must be used within 28 days after opening for in use, not in use, room temperature, or refrigerated.Review of medication insert for insulin injection pen Basaglar KwikPen revealed page 25 stated the pen currently jn use should be thrown away after 28 days, even if it still has insulin in it.2.Record review revealed Resident #23 was admitted to the facility on [DATE] with diagnoses including type II diabetes mellitus, panniculitis, sleep apnea, chronic kidney disease, asthma, anemia, neuropathy, peripheral vascular disease, gout, cognitive communication deficit, major depressive disorder, and anxiety.Review of Resident #23's quarterly MDS section N for medications completed [DATE] revealed the resident received insulin and received seven insulin injections over the past seven days.Review of Resident #23's care plan completed [DATE] revised [DATE] revealed Resident #23 was at risk for hyperglycemic and hypoglycemic reactions related to diabetes. Interventions include to administer medications as ordered.Record review revealed an order for Resident #23 for insulin injector pen Lantus subcutaneous solution 100 unit/ML to inject 30 units subcutaneously in the morning for diabetes mellitus.Observation on [DATE] at 9:00 A.M. of hall 400 medication cart revealed an insulin Lantus injection pen with no date. The pen had 80 units missing and the plunger was sitting at 180 units.Interview on [DATE] at 9:01 A.M. with LPN # 117 confirmed the insulin pen in the top drawer labeled for Resident #23 has been used, and did not have a label or date of opening on it. LPN #117 stated she was unsure when it was opened.Review of facility policy titled Medication Labeling and Storage (revised February 2023) revealed if the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. Medications are stored in an orderly manner and cabinets, drawers, cards, or automatic dispensing (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	systems. Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices.

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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 record review and staff interview, the facility failed to ensure laboratory tests were obtained as ordered by the physician. This affected one (Resident #29) of five residents reviewed for unnecessary medications. Findings include: Review of Resident #29's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included mixed hyperlipidemia (a condition characterized by elevated levels of multiple types of lipids (fats) in the blood). Review of Resident #29's physician's orders revealed the resident had an order in place to obtain a lipid profile every six months to be obtained in the months of June and December. The order originated on 06/03/25. Further review of Resident #29's electronic medical record (EMR) revealed it was absent for any documented evidence of a lipid profile being obtained as ordered every six months beginning on 06/03/25. Laboratory tests were scanned and uploaded under the documents tab of the EMR. Laboratory tests had been obtained from the resident several times, since the order was given on 06/03/25, but none of them included a lipid profile. On 09/04/25 at 11:50 A.M., an interview with the Director of Nursing (DON) confirmed Resident #29 had an order to obtain a lipid profile every six months that had been in place since 06/02/25. She reported she was not able to find evidence that it had been completed as ordered. She indicated the resident had been in and out of the hospital since then, but could not find labs to show it had been collected while in the hospital. She acknowledged his EMR showed labs for other diagnostic testing had been obtained on 06/02/25, 06/14/25, 06/16/25, 06/30/25, and 07/07/25 while the resident was in the facility, but none of them included a lipid profile.

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F 0805 Level of Harm - Minimal harm or potential for actual harm 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 observation, medical record review, dietary card review, policy review and interview, the facility failed to serve food to meet the resident needs. This affected one resident (#9) of four residents sampled for nutrition. The census was 48. Findings Include: Medical record review revealed Resident #9 was admitted on [DATE] with diagnoses including dysphagia, oropharyngeal phase. Review of the annual Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #9 was moderately impaired for daily decision-making, received a therapeutic and mechanically altered diet, and was edentulous.Review of the care plan: At Potential Risk of Nutritional Decline related to the resident's need for a mechanically altered diet revised 07/17/25 revealed interventions included to provide her diet and supplement per dietitian recommendation and physician order. Review of the electronic Clinical Physician Orders dated September 2025 revealed Resident #9 was ordered a regular diet, soft and bite-sized textures and thin consistency liquids. Review of the Dinner Tray Card dated 09/03/25 dinner meal revealed the resident diet was regular with soft and bite-size texture.On 09/03/25 at 5:13 P.M. , observation of the dinner meal revealed Resident #9 was served her meal as she was seated in a straight back chair in her room in front of an overbed table with her back towards the doorway to her room. The resident meal tray could not be completely viewed at the time of the observation. On 09/03/25 at 5:17 P.M., observation of the residents meal tray in her room revealed a hot dog on a bun, baked beans, a scoop of boiled potatoes, a bowl of diced apples, eight ounce glass of fruit punch and a styrofoam cup of hot chocolate. The hot dog was cut into five uneven pieces ranging from 0.5 inch to 1.0 inch in length. There were no condiments on the hot dog and the bun extended beyond the meat of the hot dog. No staff was observed in the room with the resident. On 09/03/25 at 5:19 P.M., observation with Licensed Practical Nurse (LPN) #120 verified Resident #9 was holding the last cut piece of one-inch hot dog on a bun in her right hand as she was chewing another bite of hot dog and bun in her mouth. LPN #120 asked the resident about the hot dog and she stated she was fine as she put the last one-inch piece of hot dog with bun into her mouth. The resident was edentulous. LPN #120 verified she was the resident's nurse but was not sure what diet she was on. After reviewing the diet card on the resident's meal tray, LPN #120 verified the resident was to receive soft, bite-sized textured foods. LPN #120 verified a hot dog cut into 1/2 to one-inch pieces would not be considered soft, bite-sized textured foods. On 09/11/25 between 10:29 A.M. and 10:47 A.M., phone interview with Registered Dietitian #203 verified a hot dog was not considered to be part of a soft diet and the hot dog on a bun in 1/2 inch to one inch pieces would not be considered to be bite-sized. The facility stated they did not have a policy for review that defined a soft diet with bite-sized texture.This deficiency represents non-compliance investigated under Complaint Number 2593047.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the facility's cycle and special diet menus, observation, and interview, the facility failed to ensure a resident received the appropriate therapeutic diet as ordered by the physician for management of end stage renal disease with dependence on hemodialysis. This affected one (Resident #6) of one resident reviewed for dialysis and nutrition. Findings include: Review of Resident #6's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included chronic kidney disease- stage IV (severe). Review of Resident #6's physician's orders revealed the resident had an order in place to receive a renal diet. The diet order originated on 07/24/25. Her physician's orders also indicated the resident received hemodialysis at a dialysis center. Review of Resident #6's 5-day Medicare (MCR) Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and was cognitively intact. She did not display any behaviors and was not indicated to have refused any care. She required set up or clean-up assist for eating. She was coded on the MDS assessment as having received dialysis while a resident in the facility. Review of Resident #6's active care plans revealed the resident had a care plan in place for being a potential risk of nutritional decline related to the medical diagnosis of chronic kidney disease- stage IV with dialysis and use of a therapeutic diet. The goal was for the resident to receive and tolerate her diet as ordered. The interventions included providing the resident with the diet as ordered by the physician. Review of Resident #6's progress notes revealed a nutrition review note completed on 07/23/25 at 5:44 P.M. (following the resident's readmission to the after a hospital stay) indicated Resident #6 was on a no added salt diet at the time. He continued to receive dialysis twice a week at a dialysis center. The dietitian recommended to discontinue the no added salt diet and change the resident's diet to a renal diet. On 09/02/2025 10:45 A.M., an interview with Resident #6 revealed she was not sure if she was receiving the appropriate diet she was supposed to receive, as she often got food she did not thinks she should have. She knew she was supposed to avoid foods that were high in potassium. On 09/08/25 at 7:45 A.M., an interview with Certified Nursing Assistant (CNA) #146 revealed Resident #6 attended dialysis twice a week. She was aware of the resident being on a renal diet, but did not know what foods should be avoided when on a renal diet. She stated she would have to check to get that information. She reported the resident had a decreased appetite and would often refuse to eat to include when alternate meals were offered. On 09/08/25 at 7:50 A.M., an observation of Resident #6 noted her to be sitting up in bed eating her breakfast. Her meal ticket was noted to identify her as being on a renal diet, but there was no information on the meal ticket to indicate what food should be avoided. A follow up interview with the resident at the time of the observation revealed the facility staff did provide her with food that she was not supposed to receive based on her renal diet. She reported the staff gave her things, such as bananas, potatoes, tomatoes, and orange juice, despite those things being items she should avoid while on a renal diet. She recalled being given a whole banana during one of her breakfast meals, but did not eat it as she did not like them. She has also received mashed potatoes as part of some of her meals, but did not eat them, as she did not care for them either. She had received orange juice in the past, but could not recall when that was. She reported they sent out tacos for one of her meals yesterday. There was salsa on the side that included tomatoes she was not supposed to eat. On 09/08/25 at 10:45 A.M., an interview with LPN #115 revealed Resident #6 was receiving dialysis twice a week on Mondays and Thursdays. She reported the resident was on a renal diet. She was asked what foods should be avoided on a renal diet and replied that would be a question for dietary. She thought it may include a low sodium diet, but she was not sure and stated she did not know the details of a renal diet. On 09/08/25 at 11:45 A.M., a second meal observation was completed for the lunch meal that day. The resident ate her meal in her room and was served cabbage rolls, red potatoes, and a brownie. She (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	refused the meal when served and was offered an alternate, but refused that also. Review of her meal ticket revealed it identified her as being on a renal diet but again did not specify foods that should be avoided. The meal ticket included beef and broccoli as the entree and fluffy rice as the starch. The meal ticket had been marked out over top of the beef and broccoli and fluffy rice and someone had added a cabbage roll under the entree and red potatoes as the starch. Findings were verified by CNA #115 that the resident was served a cabbage roll and red potatoes with her meal. Review of the cycle menu (to include all special diets) for the lunch meal served on 09/08/25 revealed the renal diet was to include beef and broccoli with chicken [NAME], fluffy rice, squash medley, a wheat dinner roll, and a blonde bar for dessert. The resident was provided the food items that were to be given to residents on a regular diet that included the cabbage rolls and red potatoes. On 09/08/25 at 12:27 P.M., an interview with Dietary Director #148 revealed the residents on a renal diet should have been given the beef and broccoli with fluffy rice as was specified on the special diet menu. She confirmed Resident #6 was not provided the appropriate diet as ordered, as the resident was not given beef and broccoli and rice as the renal diet menu called for. She reported that was her fault. She denied Resident #6 had asked for those food items for her lunch meal as part of a select menu. She acknowledged the resident had reported she has received other food items that should not be given to someone on a renal diet to include bananas, tomatoes, and potatoes. She was asked what foods someone on a renal diet should avoid, and replied foods high in potassium naming tomatoes as one of the foods she should not have. She further acknowledged the resident reported she had tacos for one of her meals the day before and the dietary staff had provided her with salsa on the side. She stated the dietary staff should be checking to make sure proper diets were provided to the residents from the kitchen during meal service. Review of the policy on Therapeutic diets (not dated) revealed therapeutic diets were prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences. Diet would be determined in accordance with the resident's informed choices, preferences, treatment goals, and wishes. A therapeutic diet must be prescribed by the resident's attending physician. The attending physician may delegate that task to a registered or licensed dietitian as permitted by state law. A therapeutic diet was considered a diet ordered by a physician, practitioner, or dietitian as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet.

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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 record review and interview, the facility failed to ensure a resident's medical record was complete to include completion dates of consents for immunizations. This affected one resident (#3) of five residents reviewed for infection control. The facility census was 48. Findings include:Record review revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including polyneuropathy, end stage renal disease, and atrial fibrillation. Review of a Minimum Data Set, dated [DATE] revealed Resident #3's cognition remained intact. Review of an Influenza Vaccine Consent Form revealed Resident #3 declined the vaccine and the document was not dated. Review of a Pneumococcal Vaccine Consent Form revealed Resident #3 declined the vaccine and the document was not dated. Review of a COVID Vaccine Consent Form revealed Resident #3 declined the vaccine and the document was not dated. Interview on 09/09/25 at 1:27 P.M. with Director of Nursing confirmed the consent forms for flu, pneumonia, and COVID vaccinations were not dated.