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	03/09/2026

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the facility's water management program, observation, interview, and policy review the facility failed to ensure enhanced barrier precautions were implemented per orders/care plan for three residents (Resident #11, #22 and #28) and the water management program was implemented per the facility's protocol. This affected three residents (Resident #11, #33 and #28) of three residents observed for enhanced barrier precautions but had the potential to affect all 38 residents residing in the facility related to the water management program. Findings include: 1. Medical record review revealed Resident #11 was admitted to the facility on [DATE] with diagnoses including end stage renal disease, paraplegia, neoplasm of colon, need for assistance with personal care, and neuromuscular dysfunction of bladder. Review of Resident #11's current orders dated 02/2026 revealed catheter care every shift, change indwelling urinary catheter (facility identified as foley) every month and as needed, monitor two lumen catheters in left chest every shift, and enhanced barrier precautions (EBP) (staff to utilize gowns and gloves for high-contacted resident care activity due to placement of an indwelling medical device). Observation on 02/23/26 at 8:30 A.M., revealed Resident #11 had an EBP sign on the door frame. There was no evidence of a personal protective equipment (PPE) cart outside the room for staff to don PPE prior to entering the resident's room. Observation on 02/23/26 at 8:33 A.M., revealed Certified Nursing Aide (CNA) #568 exited Resident #11's room with a plastic bag of linens. There was no evidence of a PPE cart in the room or outside the room. The CNA confirmed she had just performed urinary catheter care for Resident #11. The surveyor asked the CNA about PPE and if it was worn while the CNA provided care to the resident. The CNA verified she had only worn gloves while providing catheter care to the resident but she should have also worn a gown since the resident was on EBP. 2. Medical record review revealed Resident #38 was admitted to the facility on [DATE] with diagnoses including neuromuscular dysfunction of bladder, need for assistance with personal care, urinary device, personal history of methicillin resistant staphylococcus aureus infection (MRSA) and urine retention. Review of Resident #38's orders revealed indwelling urinary catheter care every shift, change urinary catheter per facility's policy, EBP (use gown and gloves for high-contact resident care, including dressing, bathing, showering, transfers, hygiene care, changing lines, changing briefs, assisting with toileting, dressing changes, and care of any device (trach, central line, tube feeding, catheter) for reducing the chance of spreading infections, treatments to open areas on the left buttocks and right medial thigh. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Observation on 02/23/26 at 8:33 A.M., during the initial tour revealed Resident #38 had a sign outside her room for EBP, however there was no PPE cart observed outside the room or in the room. During the observation CNA #551 entered Resident #38's room without applying PPE and provided direct care to Resident #38 and exited the room. Licensed Practical Nurse (LPN) #528 confirmed CNA #551 should have worn PPE when providing direct care to Resident #38 because she had a urinary catheter and open wounds. LPN #528 provided education to CNA #551. Interview on 02/23/26 at 9:15 A.M., with CNA #551 confirmed she had provided direct care to Resident #38 without wearing PPE because she didn't see the sign on the door frame that indicated the resident was on EBP. 3. During the initial tour on 02/23/26 at 8:33 A.M., with LPN #532, who was also the Infection Preventionist (IP) revealed Resident #22 had a sign outside their rooms for EBP, however no PPE cart was observed outside or inside the resident's room. LPN #523 reported Resident #22 was on EBP for wounds. Interview on 02/23/26 at 2:58 P.M., with LPN #532 confirmed CNA #568 should have worn gloves and gown during catheter care and CNA #551 should have worn PPE when providing direct care to Resident #38 because she had a urinary catheter and wounds. Review of the facility policy titled Enhanced Barrier Precautions (EBP) dated 2001 revealed EBP are utilized to reduce the transmission of multi-drug-resistant organisms (MDRO's) to residents. EBP are used as an infection prevention and control intervention to reduce the transmission of multi-drug-resistant organisms (MDROs) to residents. EBP's employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. Gloves and gowns are applied prior to performing the high contact resident care activity (as opposed to before entering the room). PPE is changed before caring for another resident. Examples of high-contact resident care activities required the use of gowns and gloves for EBP's including dressing, bathing/showering. transferring, provide hygiene, changing lines, changing briefs or assisting with toileting, device are used (urinary catheter) and wound care (any skin opening requiring a dressing. EBP's are indicted for resident infected or colonized with Centers for Disease Control (CDC) targeted or epidemiologically important MDRO. Signs are posted in the door or wall outside the resident's room indicating the type of precautions and PPE required. PPE is available outside of the residents' rooms. Resident families and visitors are notified of the implementation of EBP thought out the facility. 4. Review of the facility Water Management Plan revealed that areas of the facility subject to Legionella were: ice machines, dead legs, less frequently used areas, water heaters, respiratory therapy equipment, HVAC-PTAC units, and faucet aerators and shower heads. (The facility currently did not have residents residing in resident rooms on two of four hallways of the facility- roomm). Review of the control measures for the Water Management Plan revealed control measures included: less frequently used areas including soiled utility rooms, medication rooms, shower rooms, and empty resident rooms. The plan stated that a weekly task would include going to all these less frequently used areas and run both hot and cold water for three minutes. Review of weekly check sheets from 02/04/26 through 02/25/26, titled water management program assessment and monitoring weekly check, revealed the sheets only included resident room numbers (all resident rooms) with a check mark. The weekly check sheets did not indicate what was being done at the time of the checks and did not include other less frequently used areas identified (soiled utility rooms, medications rooms, shower rooms). Interview with Maintenance Director #524 on 03/03/26 at 8:45 A.M. confirmed the (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	weekly check sheets only included resident room numbers and a check mark. He confirmed the check sheet did not specify what was being checked at the time of the weekly checks. He stated this was the form used to run both hot and cold water for three minutes in the less frequently used areas. He confirmed the areas identified by the facility as less frequently used (soiled utility rooms, medications rooms, and shower rooms) were not included on the weekly check sheet. In addition, review of a form titled weekly checks for hot/cold water temperatures in shower rooms, bio room, soiled linen, and empty rooms for 01/07/26 through 02/28/26 revealed that it had check marks only. No temperatures were documented. Interview with Maintenance Director #524 on 03/03/26 at 8:45 A.M. confirmed he monitored hot water temperatures but did not document what the temperatures were or should be. He also stated he felt he needed further education about the facility's water management plan.

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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 complete a comprehensive assessment for a resident who had an identified weight gain and diagnosis of congestive heart failure and failed to notify staff of a physician ordered fluid restriction. This affected one resident (Resident #31) of four residents reviewed for nutrition. The facility census was 38.Findings include: Review of Resident #31's medical record revealed an admission date of 08/09/24 and diagnoses including atrial fibrillation, dementia, chronic obstructive pulmonary disease, chronic respiratory failure, persistent mood disorder, hypertension, and cardiomegaly.Review of Resident #31's care plan revealed the resident being at risk for decreased cardiac output and abnormal lab values related to atrial fibrillation, hyperlipidemia, hypertension, use of anticoagulant medication, cardiomegaly, CHF(Congestive heart failure) Date Initiated: 08/19/2024 Revision on: 12/02/2025. The care plan goal was for the resident to have no s/s of decreased cardiac status as evidenced by no shortness of breath, no complaints of chest pain, vital signs with in normal limits, and no increased edema. Date Initiated: 08/19/2024 Revision on: 09/10/2025 Target Date: 02/16/2026. Care plan interventions include: Elevate head of bed as tolerated, date Initiated: 08/19/2024, Elevate legs as tolerated, date Initiated: 08/19/2024, Encourage to follow up with cardiologist with any changes in condition, date Initiated: 08/19/2024, Give medications per physician order, date Initiated: 08/19/2024, Monitor extremities for s/s compromised circulation: discoloration, coolness to touch, decreased/absent pulses, pain with elevation, pallor, edema, muscle wasting, thick/mycotic toenails, date Initiated: 08/19/2024, Monitor for adverse affects of anticoagulant meds: abnormal bleeding, blood in stool, urine, emesis, mucous & gums; c/o abdominal pain, back pain, severe headaches; check skin for bruises, cuts, scratches, date Initiated: 08/19/2024, Monitor for indicators of hypotension, including: dizziness or light-headedness, fainting/syncope, lack of concentration, blurred vision, nausea, cold clammy pale skin, rapid shallow breathing, fatigue, depression, thirst, date Initiated: 08/19/2024 and weigh per doctor's order, date Initiated: 08/19/2024. Review of Resident #31's quarterly Minimum Data Set (MDS) dated [DATE] revealed a brief interview for mental status score of 05 indicating the resident had severe cognitive impairment. Further review of the MDS revealed Resident #31 used a wheel chair for mobility, required substantial/maximal assistance with showering/bathing and bed mobility, was dependent on staff for toileting hygiene and for transfers, and was always incontinent of bladder and frequently incontinent of bowel. Review of Resident #31's physician's orders revealed an order dated 02/14/26 for weights one time a day for congestive heart failure (CHF), notify Medical Doctor (MD) of (a) three pound (weight) gain/loss in 24 hours. The resident was not on a diuretic medication at this time for CHF.Review of Resident #31's medication and treatment administration records for February 2026 revealed Resident #31 weighed 216.8 pounds on 02/21/26, on 02/22/26 weighed 214 pounds, on 02/23/26 weighed 220.2 pounds. Review of Resident #31's progress notes revealed a note dated 2/23/2026 at 6:39 A.M. written by Registered Nurse (RN) #549 that read Med One notified of 6.2 (pound) lb weight gain in 24 hours No N.O.at this time. (There was no documentation of the resident's condition or an assessment of the resident's condition at the time of the weight assessment/report of the resident's weight gain to the on call provider.Review of Resident #31's progress notes revealed a note dated 02/24/26 at 12:00 A.M. by Certified Nurse Practitioner (CNP) #890 indicating CNP #890 discussed a plan with the resident family and staff to promote elevation of the residents legs due to peripheral edema. CNP #890 noted the resident had a six pound weight gain on 02/23/26. An observation on 02/24/2026 at 2:32 P.M. revealed Resident #31 to be resting in, bed sitting upright at a 90 degree angle with his bilateral hands and lower forearms observed to be very swollen. An observation on 02/25/2026 at 7:53 A.M. revealed Resident #31 to be up in his wheelchair moving about the facility with his bilateral hands and lower forearms observed to remain very puffy and swollen. An observation on 02/25/26 at 4:20 P.M. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	revealed Resident #31's bilateral hands and lower forearms to remain swollen.Review of Resident #31's physician's orders revealed an order dated 02/26/26 with a start date of 02/26/26 to encourage (the) resident to elevate (his) legs as he allows every shift, to wear knee high ted hose every shift, a start date of 03/02/26 for weekly weights one time a day every Monday for CHF, notify (Medical Doctor) MD of (a) five pound (weight) gain/loss in 24 hours. Further review of Resident #31's physician's orders revealed an order dated 02/27/26 with a start date of 03/02/26 for Lasix oral tablet 20 milligrams (mg) give 10 mg by mouth one time a day every Monday, Wednesday and Friday for weight gain.Additional review of Resident #31's physician's orders revealed an order dated 02/26/26 with a start date of 02/26/26 for a 2,000 milliliter (ml) fluid restriction and to serve 1,440 ml for dietary per day. Dietary amount per meal: Breakfast 480 ml, lunch 480 ml, and dinner 480 ml. Review of Resident #31's progress notes revealed a note dated 02/26/26 at 12:00 A.M. written by Physician #889 indicating the resident was seen for weight gain with his most recent weight being 217.6 pounds. Further review revealed Physician #889 indicated the resident had been noted to have increased edema, was medically stable and had a past history of atrial fibrillation but no mention of was made of congestive heart failure in the available documentation. In an interview on 02/26/2026 at 10:00 A.M. the Director of Nursing (DON) revealed that for a resident on daily weights with a weight gain greater than the order parameters she would expect the nurse to reweigh the resident to ensure the weight was correct, to notify the resident's medical provider. The DON stated that she would expect a registered nurse caring for a resident with a weight gain greater than the order parameters to have done a respiratory assessment on the resident and to have assessed the resident for edema or an increase in edema. The DON revealed that she would have expected the nursing staff to have reapproached a resident, who was on daily weights with a recent gain, throughout the day to try to get a weight.Review of Resident #31's progress notes revealed a note dated 2/26/2026 at 2:36 P.M. written by RN #545 that indicated Dr. saw resident today. New orders (were given) for Fluid Restrictions 2000 ml /24hr. [NAME] Hose knee highs and Elevate legs as resident allows. Resident and daughter in law notified.An observation on 03/03/2026 at 8:15 A.M. revealed Resident #31 eating breakfast in his room. On Resident #31's breakfast tray there was an empty 240 ml container of milk, an empty 120 ml container of juice and a water glass with 360 ml of ice water. Resident #31's meal ticket was present on the tray and did not indicate the resident was on a fluid restriction.In an interview on 03/03/26 at 8:20 A.M. Certified Nursing Assistant (CNA) #561 verified Resident #31's breakfast tray contained an empty 240 ml container of milk, an empty 120 ml container of juice and a water glass with 360 ml of ice water and that Resident #31's meal ticket is used by nursing and dietary to ensure the resident gets the correct diet type, texture and amounts of food and fluids was present on the tray and did not indicate the resident was on a fluid restriction. CNA #561 stated she was not aware Resident #31 was on a fluid restriction.Review of the policy titled Encouraging and Restricting Fluids revised 10/2010 revealed the resident water pitcher and/or water cup should be removed from the room and the specific instructions for the fluid restriction would be followed.

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F 0742 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, facility policy review and interview, the facility failed to implement a comprehensive, individualized and effective behavioral health plan to address Resident #22's mental health needs related to depression. This affected one resident (Resident #22) of three residents reviewed for behavioral/emotional needs.Actual psychosocial harm occurred beginning on 10/31/25 when Resident #22 was assessed to have a deterioration in mental health with increase in depression symptoms with request to speak to a therapist. The facility failed to obtain the requested services for the resident. The resident's mental health continued to decline. Interview on 02/23/26 with Resident #22 revealed he had still not been provided the necessary mental health therapy services; he had completely isolated himself to his room, isolated from his family, which was his support system and was not routinely bathing due to his worsening depression.Findings included: Record review revealed Resident #22 was admitted to the facility on [DATE] with diagnosis including anxiety, need for assistance with personal care, insomnia, and depression. Review of the resident's hospital Discharge summary, dated [DATE] and authored by Medical Doctor (MD) #900, revealed Resident #22 did have some mention of depression due to his current situation, and he was seen in consultation by neuropsychology with impression and recommendation as follows: patient describes longstanding history of recurrent depression which has been only recently addressed. He also reports increased anxiety. The resident had a longstanding history of post-traumatic stress disorder (PTSD) which has also never been formally treated or addressed. He is currently being treated from a psychopharmacological standpoint with bupropion (anti-depressant) 300 milligram (mg) daily, Zoloft (anti-depressant) 100 mg daily and trazadone (anti-depressant) 100 mg nightly. The hospital discharge summary included the MD strongly recommended outpatient follow-up with psychiatry for ongoing monitoring and management of psychiatric condition. The resident would also benefit from outpatient counseling and stated he had initiated the process prior to hospitalization. MD #900 recommended case management to work with him to confirm he does in fact have outpatient follow-up for mental health service. Outpatient mental health services would be helpful in both managing the resident's depression and anxiety as well as monitoring sobriety. Continued review of the hospital discharge summary revealed the resident was independent for oral hygiene and upper body dressing, required (staff) set-up assistance with bathing himself and toilet transfer. Resident #22 required (staff) partial/moderate assistance to brush hair, shower, and transfer, substantial to maximum (staff) assistance with lower body dressing and was dependent on staff for toileting hygiene. In terms of his cognition and communication, the resident was independent for all tested tasks. The resident was stable to discharge. Review of Resident #22's admission social service assessment authored by Social Service Designee (SSD) #502 dated 12/12/24 revealed the resident had a drug history and previous psychological or psychiatric intervention. The resident reported he was in a psychiatric hospital in 9th grade but couldn't remember the name. The resident reported he struggled with depression. The resident reported he had experienced or witnessed a traumatic event in his life. Please note, per the assessment, the event was described as childhood trauma. The assessment asked if the care plan reflected the resident's needs and wishes related to trauma. The assessment was marked no. Additionally, the assessment indicated the resident had no cognitive impairment and planned to discharge back to the community (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #22's plan of care for the use of psychotropic medications (antidepressants and hypnotics) related to depression, anxiety, and insomnia dated 12/19/24 and revised 09/10/25 revealed to monitor and document and report to MD signs and symptoms of depression unaltered by antidepressants medication: sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, mood, agitation, disruptive sleep, fatigue, lethargy, does not enjoy usual activities, changes in weight/appetite, and unrealistic fears Review of Resident #22's psychosocial-behavior plan of care, dated 03/05/25 and revised on 10/15/25, revealed the resident had anxiety, depression, and insomnia. The resident frequently refused care such as bathing and weights. Interventions included to have activities assess for diversional activities, monitor behaviors, document and record behavioral episodes, encourage resident to verbalize feelings, maintain a calm, slow, understandable approach, and staff to encourage resident to bathe on scheduled shower days. Please note, there was no evidence of coping skills or interventions to be used, specific to the resident, as identified in consultative behavioral health visits. Review of Resident #22's activities plan of care dated 03/21/25 revealed the resident was at risk for social isolation due to depression, prefers to stay in room, and social withdraw. Interventions included to educate on the importance of social interactions, encouraging and assist in engagement in activities, encourage verbalize/communicate feelings, maintain daily activity routine, provide activity materials, introduce to peers who share similar interest, and reassure resident their safety and your respect for their wishes. Review of a consulting behavioral health note, from former Licensed Social Worker #577, dated 08/01/25, revealed the resident was seen for anxiety, depression, mental health history, and substance use/recovery support. The resident was alert and oriented times four and open and cooperative. The resident was seen today for continuation of therapeutic support and pet therapy services. The resident reported he was experiencing fluctuation in mood, describing himself as feeling up and down. He acknowledged emotional difficulty with today being this providers final session, stating he was trying his best not to freak out. Despite this, the resident expressed he felt he was continuing to make progress and takes steps forward. Continued review of the consulting behavioral health note revealed Resident #22 continued to pursue a power chair to enhance his independence and remained engaged in facility life, including attending daily lunches in the dining room and participating in activities when able. The resident's awareness of depressive symptoms, acknowledging a lack of motivation, but stated he was making efforts to leave his room [ROOM NUMBER]-2 times per day, even if only briefly. The resident's thought process was logical, organized, and future oriented. Interventions included therapeutic support and reassurance, development and monitoring of behavioral health plans, and pet therapy. Review of a progress note from previous Consulting Psychiatric Medical Doctor (MD) #888 dated 09/05/25 revealed the resident had put on weight and was no longer able to effectively bathe himself and was resistant to getting bathed now. Today remains unkempt and malodorous. The note revealed the resident would like to see a therapist. He was seeing someone from ViaQuest, but MD #888 did not believe they were therapists. The note revealed the resident slept adequately, attended some activities, was out of his room some and had no side effects to medications. The note included the resident felt he was on a reasonable regimen. He talks to his family on the phone. Continued review of the consulting behavioral note revealed Resident #22 had affective disorder and anxiety. The resident's symptoms were worsened by social stressors and improved with stability. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	The resident had a history of depression going back to his teens. The resident was homeless; due to the house he inherited was sold for back taxes while he was in the hospital and he couldn't do anything about it. He had an [AGE] year-old son. His father committed suicide when he was young. The resident had difficulty sleeping, little interest, depressed or hopeless, and crying spells. As a teenager, he wrote a letter to his mom considering suicidal ideations, but no attempts. He formally drank seven days a week and used drugs since he was teen but quit over a year ago. This childhood was chaotic. The resident exam indicated the resident's abnormals included obese, disheveled, malodorous, abnormal gait, fair judgement concerning everyday activities/social situations, and fair insight concerning psychiatric condition. The plan for generalized anxiety was to continue Effexor (anti-depressant) at current dose, insomnia was fair and to continue on Belsomra (sedative/hypnotic) 20 mg at bedtime and Trazadone (anti-depressant) 100 mg at bedtime, and for the recurrent major depressive disorder continue Effexor 150 mg daily. The plan noted the resident was a candidate for therapy. Record review revealed there was no documented evidence the resident was referred to see a therapist/therapy or that individualized and effective interventions were in place related to the resident's depression. However, the facility developed a plan of care, dated 09/10/25 (revised 01/06/26) which indicated the resident was resistive to care related to depression, anxiety, and pain. He refused bathing, weights, and leg wraps. The intervention included allow the resident to make decisions about treatment regimen, to provide sense of control. Educate resident/family/caregivers on the possible outcomes of not complying with treatment or care. Encourage as much participation/interaction by the resident as possible during care activities. Give clear explanation of all care activities prior to and as they occur during each contact. If possible, negotiate a time for activities of daily living so that the resident participates in the decision-making process. Return at the agreed upon time. Praise the resident when behavior is appropriate. Provide resident with opportunities for choices during care provision. Record review revealed no evidence the facility associated his resistance to care with an increase in his depression. Review of Resident #22's quarterly Minimum Date Set (MDS) assessment dated [DATE] revealed the resident's cognition was intact. The assessment noted the resident had little interest or pleasure 7-11 days, feeling down, depressed, or hopeless, 12-14 days, feeling tired or having little energy 7-11 days, feeling bad about yourself or that you are a failure or have let yourself or your family down 2-6 days, and had thoughts that he would be better off dead, or of hurting self in some way 2-6 days[KA1.1][AE1.2][SP1.3][KA1.4][AE1.5]. The resident had no behavior. Diagnoses included debility, malnutrition, anxiety, depression, asthma, respiratory failure and medication included anti-depressants, hypnotics, and opioids. The previous MDS, dated [DATE] revealed the resident had no mood or behaviors. Following the completion of this MDS, no changes were noted to be made to the resident's plan of care to address the identified mood changes[KA2.1][AE2.2]. Review of a ViaQuest Therapeutic Behavior Service (TBS) note authored by TBS #575 (TBS provided assistance with coping skills but was not a licensed therapist or permitted to provide therapy services) dated 09/17/25 revealed resident's care plan objectives were to improve depression by engaging and increase social activities outside of the home evidenced by participating in two activities per week and learning and implementing one coping skill per week. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	Review of the care plan revealed no revision to include the interventions discussed with the TBS during sessions such as coping skills and breathing techniques, activity engagement. And no revisions to include the information from the MDS such as letting your family down, feeling better off dead, etc. Review of Resident #22's quarterly MDS assessment dated [DATE] revealed the resident cognition was intact. The assessment revealed the resident had little interest or pleasure 12-14 days, feeling down, depressed, or hopeless, 12-14 days, trouble falling or staying asleep or sleeping too much 12-14 days, feeling tired or having little energy 12-14 days, feeling bad about yourself or that you are a failure or have let yourself or your family down 12-14 days, trouble with concentration 12-14 days, moving or speaking so slowly that other people have noticed 12-14 days. His behaviors included rejection of care 1 to 3 days. Diagnoses include debility, malnutrition, anxiety, depression, asthma, respiratory failure and the medication section was skipped. Review of a behavior progress note, dated 10/31/25 from previous MD #888 (not contained as part of the resident's medical record) revealed the resident was difficult to motivate things. Says he needs a therapist to help him. Needs medication changes. He had fallen this morning and was not bathing. He devalues all suggestions. MD #888's plan included treatment for the anxiety to encourage bathing, dressing, and activities, which he devalues each. The plan was to increase Effexor gently to 187/5 mg daily. The resident spent much of the day in bed and was not willing to increase hypnotics further. The note included for recurrent major depressive disorder, look for solutions as far as a therapist or medication. Adjust Effexor to 187.5 mg daily. Record review revealed there was no documented evidence the resident was referred to a therapist. Review of ViaQuest Therapeutic Behavior Service (TBS) note, authored by TBS #575 dated 11/14/25, revealed the resident reported he had been to the dining room recently to eat but had not been to a group activity recently. Resident #22 stated my anxiety had been creeping in and I don't know why. Resident #22 talked about his door being shut while he was sleeping and when he woke up, he panicked. The resident reported when he was a kid his mom used to lock him in a closet while her boyfriend beat her and that door being shut brought those memories back. The resident was asked to practice Star (a calming technique designed to help manage stress and anxiety. It involves visualizing a star shape while coordinating breathing patterns to promote relaxation) breathing in session as we discussed times that he could have used it. Review of Resident #22's TBS note, authored by TBS #575 dated 12/09/25, revealed the resident was self-isolating in room and (had a) decrease in hygiene. The resident self-reported that he had not been to an activity in a while Resident stated I don't really know why other than nothing looks like it is worth the effort it takes to get down there. Resident was asked when the last time he had been to the shower room and had an odor detected and he did not want to leave his room. The resident reported he could not state the last time he went to the shower room. The TBS talked about the importance of good hygiene. The resident engaged about his star breathing coping skill and how using it can help reduce symptoms. There were no social service notes in the medical record regarding the resident's mental or psychosocial status or evidence of facility interventions to assist the resident in managing his depression from 11/14/25 through 12/10/25. Review of Resident #22's TBS note, authored by TBS #575 dated 12/11/25, revealed the resident was self-isolated and lacked hygiene. The resident (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 0742 Level of Harm - Actual harm Residents Affected - Few	self-reported that he still had not been to any activities. The resident had not been to the shower room as well. This was more than several weeks for not leaving his room. The note included we talked about consistently using star breathing and box breathing throughout the day to help reduce depression. This would help reduce symptoms and help resident stop self-isolating. Resident engaged in practicing his star breathing and box breathing (a simple, four step stress-reduction technique used to calm the nervous system, improve focus, and manage anxiety). Review of Resident #22's annual MDS assessment dated [DATE] revealed the resident cognition was intact. The resident had little interest or pleasure 12-14 days, feeling down, depressed, or hopeless, 12-14 days, trouble falling or staying asleep or sleeping too much 2-6 days, feeling tired or having little energy 12-14 days, feeling bad about yourself or that you are a failure or have let yourself or your family down 12-14 days, trouble concentration 7-11 days, moving or speaking so slowly that other people have noticed 2-6 days. Social isolation often. His behaviors included rejection of care 1 to 3 days. Activity preference clothes to wear somewhat important, personal belongings very important, choose between a tub bath, shower, bed bath, sponge bath very important, snacks very important, bedtime very important, family and friend involvement not important at all, phone in private not very important. It was very important to listen to music. It is somewhat important to keep up with new, and do things with groups of people, and do favorite activities. It was very important to get fresh air. Diagnoses include debility, malnutrition, anxiety, depression, asthma, respiratory failure and medication included anti-depressants, hypnotics, diuretics, and opioids. Review of Resident #22's annual social history and discharge planning assessment, dated 12/11/25 and authored by Social Service Designee #502, revealed the resident had a previous pill addiction. The resident reported he felt social isolation often. The resident had a history of not taking showers. The resident was not currently taking psychotropic medications (please note, the resident was receiving psychotropic medications). The note also indicated the resident had no significant life events/trauma history (Please note, the resident had previously discussed his childhood and issues with PTSD). The resident planned to become a long-term resident. The resident's quality of life objectives included engaging in hobbies, socializing, and staying active. Review of ViaQuest Nurse Practitioner (NP) note, dated 12/17/25, revealed Resident #22 was friendly and cooperative. He endorses (his) depression was 10 out of 20 which he reports as occurring comes and goes and anxiety as all of the time but varies in severity. He reports difficulty with both falling asleep and staying asleep and appetite was good. The resident reported he was compliant with medication and was requesting to talk with a psychiatrist. Talked with the resident about services of NP, nursing and therapeutic behavioral service (TBS). No changes made on this day. Discussed options of Genesight testing (a test that analyzes how your genes may affect medication outcomes) due to maximum medication dosages. The resident stated he would like to think about it. Record review revealed no documented evidence the resident was referred to a psychiatrist for follow up mental health services per his request. Review of Resident #22's psychosocial plan of care, dated 12/17/25 revealed the resident had little interest or pleasure in doing things. Interventions included assisting with conflict resolution as needed, listening alternatively, provide emotional support. There were no resident specific interventions as discussed through his consulting behavioral health sessions. Review of a facility concern form dated 01/08/26, and authored by the Administrator, revealed Resident #22 reported, while he was willing to meet with the counseling provider currently assigned (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	(ViaQuest TBS), he didn't feel the sessions were helpful or effective for him. He stated the new services did not offer the same level of support or connection he experienced previously. The resident expressed he missed his former provider and feels that the therapeutic relationship he had with former Licensed Social Worker #577 (previously employed by MD #888 and not an employee of the facility) was more beneficial. He was clear that, moving forward, he would prefer to meet only with former Licensed Social Worker #577, if possible. His concerns and preferences were acknowledged, and the resident was encouraged to continue communicating his needs so appropriate follow-up can occur. A facility corrective action included that Resident follow-up reflected after discussing his preferences for returning to his former counselor, the Administrator had contacted former Licensed Social Worker (LSW) #577 to determine whether she could resume services. LSW #577 explained she was no longer affiliated with the agency our facility currently contracts with and was now employed by a different provider. She stated she would only be able to see the resident again if our facility entered a formal contract with her new agency (employer). The plan included because we (the facility) maintain an active contract (ViaQuest) with her previous employer arranging for her to see the resident independently would constitute a breach in that agreement and was therefore not permissible. (Please note, LSW #577 was not employed with ViaQuest prior to leaving, she was employed by MD #888) The Administrator returned to the resident to update him on these limitations. He acknowledged the information and stated that, at this time, he doesn't wish to see any counselor other than LSW #577. He did not identify interest in meeting with an alternative provider but was respective to being informed of other options in the future. Review of ViaQuest Nursing Note dated 01/08/26 revealed the resident endorsed depression was related to his situation and history growing up. The resident reported he gets depressed most days and his anxiety was related to missing his family, his personal situation, and his upbringing. The resident requested a therapist. This note revealed the nurse updated the nurse practitioner (NP) as directed. The resident was educated on GeneSight testing and agreed to have testing done. Record review revealed no evidence the resident was referred to a therapist as requested at this time. Review of a TBS note, authored by TBS #575 and dated 02/17/26, revealed the resident was lying in bed and seemed to be less talkative than normal. Review of a TBS note, authored by TBS #575 and dated 02/19/26, revealed the resident had poor personal hygiene, malodor and was unkempt. The resident had not showered in over a month and had noticeable odor. The resident had also been self-isolating and overeating. The resident reported he was not showered and stated that his knees are sore from a recent fall. The resident did engage in conversation about self-isolating and how he needed to go to activities as in the past it had improved his overall mood. We talked about getting showered and cleaned up to also help improve overall mood. The resident was receptive to getting a shower when talking about the next time his young son comes to visit him he would be clean and smell good. Review of Resident #22 current plan of care, as of 03/03/26 revealed no evidence the resident had a plan of care for PTSD or any potential PTSD triggers throughout his comprehensive care plan such as leaving the resident's door open. Review of Resident #22 behavior monitoring the treatment administration record (TAR) dated 09/2025 to 02/2026 revealed staff documentation as follows: On 09/02/25 the resident had anxious, restless, and withdraw/depression, September 7th restless, (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	afraid, withdraw/depressed, and mood change; 09/08/25 mood change and withdraw/depressed; 09/09/25 afraid; 09/13/25 withdraw/depressed and afraid; 09/14/25 agitated, withdraw/depression and afraid; 09/16/25 agitated withdraw/depressed, and afraid, and September 30th withdraw/depression, anxious, and mood change. There was no documentation for rejection of care. Please note, the behavior monitoring was not specific to targeted behaviors. Staff did not document the resident had any behaviors on the TAR for October 2025, November 2025, or December 2025. On 01/15/26, the resident had agitation; 01/20/26 the resident was anxious. On 02/13/26, the resident was withdrawn/depression and 02/20/26 withdrawn/depression, other, and anxious. Observation on 02/23/26 at 2:27 P.M. revealed Resident #22 had a sign taped to his door that indicated leaving the resident's door open. Multiple observations during the onsite survey revealed the sign remained on the resident's door. Interview on 02/23/26 at 2:37 P.M. with Resident #22 revealed a concern the facility was not addressing his depression and anxiety and he needed to see a therapist. Resident #22 reported he had told the new Administrator several times he needed to see a therapist; however, nothing ever got done. The resident shared when he was first admitted he was seen by former consulting Licensed Social Worker #577, (this LSW previously saw the resident in the facility as she worked for MD #888 but left the practice of MD #888 and went on to another employer. The facility terminated their contract with MD #888 and started using services from ViaQuest). The facility recently hired a new company; however, the staff were not therapists and were just teaching him breathing techniques that didn't help him. The resident reported that some days he felt like he was going to have a breakdown. Observation of the resident at the time of the interview revealed the resident was unkempt and had malodorous odor. On 02/24/26 at 10:56 A.M., Resident #22 was observed sitting in his room with the television on. The resident reported after the conversation he had with the surveyor on 02/23/26, the facility social worker (Social Service Designee #502) had visited him and asked him what his issues were. The resident reported he told SSD #502 the same issue that had been going on and had been reported to the Administrator (in January 2026), he wanted to see a therapist. The SSD did schedule an appointment for him see a therapist in the community. The resident reported his depression, and anxiety had been so bad lately that he had not been sleeping well and his anxiety medication was not helping. Observation on 02/24/26 at 12:40 P.M., revealed Resident #22 was sitting on the edge of the bed asleep. Interview on 02/24/26 at 12:46 P.M. with SSD #502 confirmed he followed up with Resident #22 on 02/23/26 after the resident spoke with the State surveyor. The SSD revealed he had made an appointment with a therapist in the community and revealed he was unaware Resident #22 had voiced mental health concerns to the Administrator in January 2026 as the Administrator was responsible to address concerns and the concern log. Interview on 02/25/26 at 7:06 A.M., with Resident #22 revealed he had spoken with the Administrator several times, but the last time was in January 2026 regarding his desire to see a therapist. However, the resident stated he had given up asking because nothing was done about his concern. The resident (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	shared SSD #502 visited him shortly after he talked with the surveyor about his concern with mental health services and now he finally had an appointment to see a therapist. The resident stated he had started asking to see a therapist a few weeks after the former licensed social worker had left around September 2025; however, he didn't feel the Administrator addressed his concerns and would say I will follow up but never did. The resident reported his depression was worse and he had isolated himself to his room more, which was an indication his depression was worse. The resident reported his Effexor (anti-depressant) was increased a few months ago, but he stated he didn't notice a difference. The resident reported he had been staying in his room and didn't care if he got up or socialized and he had also stopped communicating with friends (mother of his son)/family and had pulled the curtain shut in his room, which was another indication his depression and anxiety were worsening. Interview on 02/25/26 at 8:03 A.M., with the Administrator revealed he had talked to Resident #22 three times; however, he only filed one complaint form (January 2026). The Administrator reported the resident wanted to see the previous contracted Licensed Social Worker #577; however, she was employed for another company now and there would be a conflict of interest so she couldn't provide services to Resident #22. Interview on 02/25/26 at 9:11 A.M., with the previous contracted LSW #577 revealed she did not speak to the Administrator in January or anytime regarding providing services to the facility or Resident #22. The LSW reported she had spoken to Resident #22, in detail, to explain she was going to a new company and would no longer be providing services to him and the resident voiced understanding. The LSW reported that if the resident needed services, the facility could reach out to her, and they could discuss potential options suitable to meet the resident's psychosocial and behavioral health needs. Interview on 02/25/26 at 10:11 A.M. with the Administrator and review of the concern form, completed in January 2026, revealed he may have talked to someone else where LSW #577 worked and not her directly about resuming services with Resident #22. Additionally, the facility stopped using the behavioral health services of MD #888 and started using ViaQuest for behavioral health services beginning 12/06/25. The Administrator stated he was unaware the resident wanted to see a therapist until the SSD followed up with the resident on 02/23/26, after the resident expressed his concerns to the State surveyor. A follow-up interview with the Administrator on 02/25/26 at 3:18 P.M. revealed he was incorrect regarding the employer for LSW #577. The Administrator verified LSW #577 was employed by MD #888 and never for ViaQuest as stated on the concern form. Interview on 02/25/26 at 1:56 P.M. with ViaQuest TBS #575 revealed she was not a therapist or counselor, and her role was to help residents identify triggers and develop coping skills to minimize symptoms but not healing past traumas. TBS reported the mental health services were newer and she was not sure what the mental services included, and she did not have access to the ViaQuest NP notes. The TBS confirmed LSW #577 did not work for ViaQuest. TBS #575 revealed each time she saw Resident #22 she had to tell him she was not a therapist. TBS #575 indicated the resident had a current behavior of overeating. She stated sometimes she talked to staff regarding the resident's coping skills but not always. Resident #22's goals this week were going to activities and getting a shower. The TBS revealed the facility didn't get a copy of her notes (from her visits) and she would have to call her office to get permission to have the records released. (The records were subsequently released and included as noted above in the survey findings). Interview on 02/26/26 at 6:35 A.M., with Licensed Practical Nurse (LPN) #501 and LPN #5

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, review of manufacturer guidelines, and facility policy review, the facility failed to ensure kitchen staff (Cooks #531 and #541) were competent with job responsibilities. This had the potential to affect all the residents in the facility. The facility census was 38. Findings include: 1.Observation of the kitchen 02/23/26 at 8:08 A.M. with [NAME] #541 and [NAME] #531 revealed the dishwasher temperatures were only being recorded in the morning and the evening. There were no temperatures recorded for the lunch dishes. Cooks #541 and #531 reported they only took temperatures twice a day, and not when they washed dishes for each meal. They reported they were recording the dishwasher temperatures on a Parts Per Million (PPM) Sanitation log, and not on a dishwasher log. The temperatures for the whole month were recorded as 160 degrees Fahrenheit (F) for the wash cycle, and 190 degrees F for the rinse cycle without variation. Every day, the same wash cycle and rinse cycle temperatures were recorded for morning and evening. Observation on 02/23/26 at 8:38 A.M. of the dishwashing cycle revealed the dish wash cycle temperature was 145 degrees F for the wash cycle and 189 degrees F for the rinse cycle. The Surveyor stated out loud that the wash cycle temperature was 145 degrees F. [NAME] #531 pulled the dishes through the dishwasher to make room for the next rack. [NAME] #541 asked the dishwasher (Cook #531) to reset the booster. [NAME] #531 did not know how to reset the booster so [NAME] #541 told him to drain the tank, hit the red button, and flip the switch. After the booster was reset at 8:44 A.M., the dishwasher wash cycle temperature was 164 degrees F and the dishwasher did not click onto the rinse cycle. [NAME] #531 was not paying any attention to what the temperature readings were and he pushed the dishes out of the dishwasher and was going to push another rack through when the Surveyor intervened and informed [NAME] #531 that the dishwasher had not clicked onto the rinse cycle. [NAME] #541 told him to put the dishes back in and rewash them. When [NAME] #531 put them back in, the wash cycle temped at 155 degrees F and the rinse cycle tempted at 164 degrees F. At 8:47 A.M., the dishwasher cycle ran again, and it washed at 154 degrees F and rinsed at 179 degrees F. At 8:50 A.M. the dishwasher washed at 155 degrees F and rinsed at 181 degrees F, at which time it reached the manufacturer recommendation of 150 degrees wash and 180 degrees rinse 2. Observation of the lunch meal tray line 02/24/26 at 10:56 A.M. revealed the meal was store-bought pasta salad, turkey and cheese croissants, green beans or mixed vegetables, and cake. Milk was listed as an available beverage. [NAME] #541 obtained a temperature of 202.8 degrees Fahrenheit for the mixed vegetables, 205.7 degrees for the pureed green beans, and 197 degrees for the regular green beans. There were no observations of the cook obtaining temperatures of the milk, pasta salad, or logging the temperatures.Review of the ingredients in the Italian pasta salad from the food supplier included the pasta salad contained mayonnaise and eggs. The facility served the Italian pasta salad to residents as planned. There was not a temperature recorded for the pasta salad prior to serving to residents.Observation 02/24/26 at 11:12 A.M. of the binder that contained the meal temperature logs included the lunch meal was recorded at 180 degrees Fahrenheit for both the vegetable and vegetable puree. The milk temperature was recorded at 33 degrees. The temperatures obtained at the start of the tray line were not recorded in the binder.Interview 02/24/26 at 11:12 A.M. with [NAME] #541 included when asked why the food temperatures the surveyor observed for the lunch meal were not written on the lunch log, he stated it only needs to reach 165 degrees. 3. Review of the personnel records for [NAME] #531 revealed a 07/21/25 date of hire. Review of the personnel record for [NAME] #541 revealed a hire date of 01/13/26. Review of the personnel records revealed there was no evidence of on-the-job training. There was no evidence that the staff was taught to run the dishwasher, reset the booster, log tray line meal temperatures, and all other job responsibilities.Interview 02/26/26 at 12:12 P.M. with Human Resource #554 verified the facility did (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	not have any documentation of on-the-job training having been completed to verify dietary staff were taught to run the dishwasher, reset the booster, log accurate temperatures for meal service tray line, and dishwashing tasks.Review of the policy Food Preparation and Service revised November 2022 included when verifying food temperatures staff use a thermometer which is both clean and sanitized and calibrated to ensure accuracy. All food service equipment and utensils will be sanitized according to current guidelines and manufacture recommendations. Proper hot and cold temperatures are maintained during food distribution and service. Foods that are held in the temperature danger zone are discarded after four hours. The temperatures of food held in steam tables are monitored throughout the meal service by food and nutrition services staff.Review of the [NAME] AM Select Dishwasher instruction manual included operating temperatures for all models listed 150 degrees F as the minimum effective temperature for the wash cycle and 180 degrees minimum effective temperature for the rinse cycle.

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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, record review, review of manufacturer guidelines, review of invoices, and interview, the facility failed to store and serve food under sanitary conditions. This had the potential to affect all residents residing in the facility. The facility census was 38. Findings include: 1.Observation of the kitchen 02/23/26 at 8:08 A.M. with [NAME] #541 and [NAME] #531 revealed the following:Observation of the walk-in freezer revealed the rib shaped pork patties, breakfast omelets, and precooked hamburger patties were left open which exposed the food to the freezer air.The walk-in refrigerator temperature log was over 41 degrees Fahrenheit since 02/04/26 and been taken out of use.The kitchen did not have a working oven. In the dry storage area, there was [NAME] pasta opened on 01/19/26 which noted it was to be disposed of on 02/19/26. There was three [NAME] pastas that were opened and undated. There was an elbow macaroni opened, not sealed, and without an open date. There was [NAME] long pasta not dated, and [NAME] long pasta not sealed nor dated. There was an additional classic [NAME] pasta opened on 12/21/25 without a disposal or discard date listed. The temporary portable refrigerator that was outside, to replace the walk-in refrigerator, had a thermometer in it that was reading 42 degrees Fahrenheit (F). The mercury thermometer the facility was using was loose in its case with one side broken off its support and moving around.Observation of the dishwasher temperature log revealed the dishwash temperatures were taken in the morning and in the evening. There were no temperatures written for the lunch dishes. They only took them twice a day not when they washed dishes for each meal. They were being recorded on a Parts Per Million Sanitation log not a dishwasher log. The temperatures for the whole month were recorded as 160 degrees F for the wash cycle, and 190 degrees F for the rinse cycle without variation. Every day, the same wash cycle and rinse cycle temperatures were recorded for morning and evening. Observation on 02/23/26 at 8:38 A.M. of the dishwashing cycle revealed the dish wash cycle temperature was 145 degrees F for the wash cycle and 189 degrees F for the rinse cycle. The Surveyor stated out loud that the wash cycle temperature was 145 degrees F. [NAME] #531 pulled the dishes through the dishwasher to make room for the next rack. [NAME] #541 asked the dishwasher (Cook #531) to reset the booster. [NAME] #531 did not know how to reset the booster so [NAME] #541 told him to drain the tank, hit the red button, and flip the switch. After the booster was reset at 8:44 A.M., the dishwasher wash cycle temperature was 164 degrees F and the dishwasher did not click onto the rinse cycle. [NAME] #531 was not paying any attention to what the temperature readings were and he pushed the dishes out of the dishwasher and was going to push another rack through when the Surveyor intervened and informed [NAME] #531 that the dishwasher had not clicked onto the rinse cycle. [NAME] #541 told him to put the dishes back in and rewash them. When [NAME] #531 put them back in, the wash cycle temped at 155 degrees F and the rinse cycle tempted at 164 degrees F. At 8:47 A.M., the dishwasher cycle ran again, and it washed at 154 degrees F and rinsed at 179 degrees F. At 8:50 A.M. the dishwasher washed at 155 degrees F and rinsed at 181 degrees F, at which time it reached the manufacturer recommendation of 150 degrees wash and 180 degrees rinse.Interview 09/23/26 at 8:50 A.M. with [NAME] #541 verified the freezer had food items open to the freezer air, items in the dry storage were opened and not sealed and/or dated, the dishwasher log had the exact same wash and rinse temperatures taken for the entire month, no dishwasher temperatures were recorded for the lunch meal in February 2026, and the dishwasher temperatures were not reaching the sanitary levels upon observation.2. Observation 09/23/26 at 9:01 A.M. of the kitchenette with Activity Director #527 revealed that they did not take any refrigerator temperatures on 02/22/26 or the evening of 02/21/26. The freezer temperature was not being recorded at all. The refrigerator contained an undated turkey and cheese sandwich with the initials SC. There was also a piece of coconut cream pie sent by the kitchen which was (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	undated.Interview 09/23/26 at 9:06 A.M. with Activity Director #527 verified the undated food items and missed refrigerator temperatures.3. Observation of the lunch meal tray line 02/24/26 at 10:56 A.M. revealed the meal was store-bought pasta salad, turkey and cheese croissants, green beans or mixed vegetables, and cake. Milk was listed as an available beverage. [NAME] #541 obtained a temperature of 202.8 degrees Fahrenheit for the mixed vegetables, 205.7 degrees for the pureed green beans, and 197 degrees for the regular green beans. There were no observations of the cook obtaining temperatures of the milk, pasta salad, or logging the temperatures.Observation 02/24/26 at 11:12 A.M. of the binder that contained the meal temperature logs included the lunch meal was recorded at 180 degrees Fahrenheit for both the vegetable and vegetable puree. The milk temperature was recorded at 33 degrees. The temperatures were not consistent with the temperatures observed during tray line temperatures. In addition, food temperatures were not being recorded consistently.Review of the February 2026 food temperature logs revealed for 02/01/26 only a supper meal was recorded. There was no temperature logs recorded for 02/02/26, 02/03/26, 02/04/26, or 02/05/26. On 02/07/26, there was only a supper temperature recorded. There were no food temperature logs for 02/08/26, 02/09/26, 02/10/26, or 02/11/26. The 02/12/26 food temperature log contained breakfast and lunch meal temperatures and no temperatures recorded for the supper meal. The food temperatures for breakfast were all recorded as 180 degrees F for the hot cereal, pancakes, French toast, and pureed bread and 33 degrees F for the milk and juice. For lunch, the entree, substitute, and the entree ground/pureed were recorded at 180 degrees F and the milk at 33 degrees F. There were no supper temperatures recorded. There were no food temperature logs for 02/13/26, 02/14/26, 02/15/26, 02/16/26, 02/17/26, 02/18/26, or 02/19/26. On 02/20/26, there were no breakfast or lunch temperatures recorded, only supper. On 02/21/26, there was breakfast and lunch temperatures recorded and no supper. The breakfast and lunch temperatures were all recorded at 180 degrees F including the breakfast eggs and hot cereal and the lunch entree, substitute, the entree ground/pureed, and the starch substitute. The pureed starch, the vegetable substitute, and the pureed vegetable were all recorded at 180 degrees F. The milk was recorded at 33 for breakfast and lunch and the juice was recorded at 33 degrees for breakfast. On 02/23/26, the same pattern was observed with all the breakfast and lunch hot foods having 180 degree F temperatures recorded and the milk, juice, and dessert recorded at 33 degrees F.Interview 02/24/26 at 11:12 A.M. with [NAME] #541 included when asked why the food temperatures the surveyor observed for the lunch meal were not written on the lunch log he said it only needs to reach 165 degrees. Review of the ingredients in the Italian pasta salad from the food supplier included the pasta salad contained mayonnaise and eggs. The facility served the Italian pasta salad to residents as planned. There was not a temperature recorded for the pasta salad prior to serving to residents on 02/24/26.Review of the facility policy Food Receiving and Storage dated 2001 included all food stored in the refrigerator or freezer are covered, labeled, and dated with the use by date. Dry goods are handled and stored in a manner that maintains the integrity of the packaging until they are ready to use. Those foods and snacks kept on nursing units, including all foods belonging to residents, are labeled with the resident's name, the item, and the use by date. All food items to be kept at or below 41 degrees Fahrenheit are placed in the refrigerator located at the nurse station and labeled with the use by date.Review of the policy Food Preparation and Service revised November 2022 included when verifying food temperatures staff use a thermometer which is both clean and sanitized and calibrated to ensure accuracy. All food service equipment and utensils will be sanitized according to current guidelines and manufacture recommendations. Proper hot and cold temperatures are maintained during food distribution and service. Foods that are held in the temperature danger zone are discarded after four hours. The temperatures of food held in steam tables are monitored throughout the meal service by food and nutrition services staff.Review of the [NAME] AM Select Dishwasher instruction manual included operating temperatures for all models listed 150 degrees F as the minimum effective temperature for the wash cycle and 180 degrees minimum effective temperature for the rinse cycle.4. Observation of (continued on next page)

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	365780	A. Building B. Wing	03/09/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the kitchen 02/23/26 at 8:08 A.M. with [NAME] #541 and [NAME] #531 revealed the walk-in refrigerator temperature log was over 41 degrees F since 02/04/26 and been taken out of use.The walk-in refrigerator was recorded at 50 degrees for the evening temperature on the 02/04/26 temperature log. To the right of the 50-degree F temperature, a temperature of 48 degrees F was written with the additional notation came to service. The facility obtained a portable refrigerator on 02/09/26 that was outside. The portable refrigerator was hooked up on 02/10/26. The temperature log for the portable refrigerator started on the morning of 02/11/26 with a reading of 36 degrees F. On 02/12/26, the evening temperature was recorded at 50 degrees F.Interview on 02/25/26 at 4:05 P.M. with Dietary Manager #538 revealed she would have taken the A.M. temperature on 02/12/26 of 37 degrees F around 5:00 A.M. when she arrived for work and the 50-degree F temperature around 4:00 P.M. before tray line. Written on the line next to 50 degrees F was less than two hours. When asked how she knew the refrigerator was not keeping temperature for less than two hours the Dietary Manager #538 stated a regional employee was doing a mock survey and found it warm. They moved everything into the reach in refrigerator. Dietary Manager #538 said she tested the milk and it was 39 degrees F, but she did not document that anywhere. A service technician came that day and had it up and running. It was later determined the regional employee was at the facility on 02/11/25 (not 02/12/25), the refrigerator was found warm around 2:30 P.M., and the refrigerator was not emptied when it was found to be 50 degrees F.Interview on 02/25/26 at 4:52 P.M. with the Administrator revealed he was not in the facility on 02/12/26 when it was discovered that the portable refrigerator was not keeping temperature. He said he was notified. On 02/13/25 at 5:10 P.M., the Administrator received a picture of four cases of drinks that were being thrown away.Interview on 02/26/26 at 9:58 A.M. with Maintenance Director #524 revealed on 02/12/26 at 2:36 P.M., Dietary Manager #538 texted him that the rental refrigerator unit was not cooling. At 2:38 P.M., he called the company he rented the portable refrigerator from, and they came out and serviced the unit. The condenser was not kicking on. It had something to do with the fan not working. He normally leaves at 3:00 P.M., but he waited to go home till they fixed the unit. They were finished fixing it by 5:00 P.M. Interview on 02/26/26 at 2:12 P.M. with [NAME] #516 revealed on 02/12/26 he clocked in and got ready. There was food in the rental refrigerator unit outside on 02/12/26. The built-in thermometer on the outside of the refrigerator read 50 degrees F. When he walked in, it was ridiculously warm. He grabbed the potato salad, it was 42 degrees F. He removed a pasteurized juice that was 50.2 degrees F, the milk was 50.4 degrees F, and the margarine was 50 degrees F. The rental refrigerator was fixed that afternoon. No one tested the milk to see what the temperature was when the repair was complete. Dietary Manager #538 left the milk in the rental unit and said maintenance would take care of it and left. [NAME] #516 reported they had never heard what to do for milk or juice for supper. The dietary staff decided to text Dietary Manager #538 and she did not reply to [NAME] #531. Dietary Aide #523 told him that Dietary Manager #538 responded to him and said she would relay the information about throwing out the milk. When [NAME] #516 arrived for work on 02/13/26, he walked out when he found out from Dietary Aide/Cook #531 and [NAME] #541 that they served the milk from the rental refrigerator for breakfast and lunch. He said he should have taken it upon himself to throw out the milk that was 50.4 degrees on 02/12/26 when he found the rental refrigerator was not cooling. [NAME] #516 reported Dietary Manager #538 said she thought the milk was fine. She spoke to the other staff and told them it would be ok. He looked for the Administrator and Human Resource. He found the Director of Nursing who called the Administrator and told him what he did to prevent the drinks that were in the rental refrigerator from being served and he had not done enough when he found out the drinks were served for breakfast and lunch. He indicated when he left on 02/12/26 there was not enough milk and juice in the reach-in refrigerator for breakfast.Interview on 03/02/26 at 10:37 A.M with Office Manager #583 revealed they received the call at 2:38 P.M. of their rental refrigerator not reaching temperature. There was a technician onsite who left and would have been at the facility by about 3:15 P.M. They diagnosed the problem and took about 15 minutes to fix. It was a (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	total of about an hour they were here total. They would have finished by about 4:15 P.M.Interview on 03/02/26 at 12:51 P.M. with Technician #590 revealed the rental refrigerator was 50.4 degrees F when he arrived at the facility. It took about an hour to diagnose, fix, and ensure the temperature dropped to normal range. It was 37 degrees F when he left. There was a coil that was bad. He relayed he had to remove shelves from the portable refrigerator to fix the rental. He moved crates of single serve milk and juice to another shelf. He said they were in the rental while he was repairing the refrigerator. Interview on 03/02/26 at 1:30 P.M. with Maintenance #524 verified he was not asked to throw away any items from the rental refrigerator. Interview on 03/04/26 at 8:23 A.M. with Dietary Aide #523 revealed the milk for supper on 02/12/26 would have been in the reach-in refrigerator when the rental refrigerator broke. He did not carry any milk inside from the portable refrigerator after they discovered it was hot. Interview on 03/02/26 at 8:57 A.M. with [NAME] #541 said he only knew the walk-in refrigerator was down. When he worked on 02/13/26, he did not know the rental refrigerator broke the day prior. He does not recall any conversation related to the warm milk or juice being thrown out. He recalls throwing out some wilted lettuce. He did not know where the milk came from that he served 02/13/26.Interview on 03/02/26 at 9:14 A.M. with Dietary Manager #538 revealed she spoke to maintenance staff, and he said the refrigerator was warm for less than two hours and that is why she wrote that on the log. Interview 03/03/26 at 11:28 A.M. with United Dairy Delivery #588 revealed he usually delivers milk twice a week, usually on Tuesdays and Fridays. He did not make any additional deliveries due to the facility having to throw products out. He was never told they had to replace milk or juice due to needing to throw it away.Review of delivery records revealed on 02/13/26, United Dairy delivered at 12:06 P.M. 200 chocolate milk cartons, a container of cottage cheese, 500 2% milk cartons, and 225 cartons of orange juice. Interview 03/03/26 at 1:49 P.M. with the Administrator revealed he received a photo at 5:10 P.M. on 02/13/26 that the milk delivery came and she was throwing away 4 cases of milk and juice. Verified they were thrown away after the breakfast, lunch and supper meals were served. No staff acknowledged getting rid of the milk and juice that remained in the rental refrigerator until 5:10 P.M. the next day. This deficiency represents noncompliance investigated under Complaint Number 2788578.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on observation, record review, review of Quality Assurance and Performance Improvement program (QAPI) meeting minutes, and interview, the facility failed to maintain an ongoing, comprehensive, and effective Quality Assurance and Performance Improvement Program to address concerns with facility practices and operations, to ensure corrective action plans from prior survey activity addressed quality concerns, systemic gaps and outcomes and corrective interventions were evaluated for effectiveness to meet the total care needs of the residents in the facility. This affected all 37 residents residing in the facility.Findings include: Review of the facility Quality Assurance and Performance Improvement program (QAPI) Meeting Sign-In Sheet, dated 02/19/26, revealed topics addressed at the meeting included findings from an internal mock survey, ensuring interventions were in place and the plan to introduce a new hall. The QAPI Action Plan included following the committee's review of February's findings, a comprehensive set of corrective and preventive action items were initiated to strengthen system reliability, reinforce staff accountability, and ensure readiness for the upcoming state survey consistent with the approach used in the October QAPI cycle where the facility initiated a comprehensive set of action items to address each citation and ensure that the corrective measures were implemented promptly, consistently, and in alignment with regulatory expectations. The February action plan focused on improving communication pathways, standardizing processes, and validating that corrective actions were fully integrated into daily operations.Further review of QAPI Minutes provided revealed no evidence the facility held a QAPI meeting after the bi-annual survey on 03/09/26 and prior to the alleged allegation of compliance date of 04/21/26 to ensure compliance was achieved with the deficiencies issued as a result of the bi-annual survey including the infection control practices/concerns and quality of care concerns.a. Review of the facility's Plan of Correction for the citation at Data tag F880 (from the Special Focus Facility Bi-annual survey dated 03/09/26) revealed beginning March 16, 2026, the Infection Control Nurse/Designee initiated random enhanced barrier precaution (EBP) audits on a minimum of five residents with EBP or isolation orders weekly for four weeks and as needed thereafter. Any issues identified in the audit process would be forwarded to the QA committee for immediate follow-up. The results of the audits would be reviewed during the QA meetings to determine if current action plan was effective or if additional interventions would need to be added.During the post-survey revisit completed on 05/15/26, Data Tag F880 was cited at a Severity Level 4 (Immediate Jeopardy) and scoped at an L which indicated the deficiency was widespread, potentially affecting all residents in the facility. The facility lacked a comprehensive infection control program to prevent the spread of RSV. The facility encountered an RSV outbreak with an infection rate of 16.2% and the death of one resident, Resident #3. Prior to the survey, the facility failed to implement comprehensive and sustainable interventions and failed to ensure staff were educated related to the communicable disease to prevent the outbreak within the facility.On 04/29/26 at 11:16 A.M. interview with Infection Preventionist (IP) #256 revealed she had not initiated contact tracing, did not have a line list (a fundamental epidemiological tool used to track individual cases during an outbreak), and did not timely identify an outbreak of RSV until 04/22/26 when three additional residents tested positive (the facility already had two positive staff members and one resident at this time). IP #256 further revealed communal gatherings of dining and group activities did not cease until 04/22/26, nor was the local health department notified of the situation until 04/22/26. On 04/29/26 at 12:37 P.M. interview with County Health Department Registered Nurse (RN) #407 revealed she was notified on 04/22/26 by IP #256 of five residents and two staff members testing positive for RSV. RN #407 stated she would have expected to be notified within 24 hours of an identified outbreak (two or more cases) and she was not. RN #407 stated following notification she emailed RSV guidance to IP #257.On 04/29/26 at 1:20 P.M. interview with Regional Director of Clinical Services RN #402 confirmed the facility only had a general policy related to RSV/respiratory infection, not a comprehensive policy or policy specific to RSV prevention, (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	monitoring or the procedure for how to address cases of RSV and prevent the spread of the disease.On 04/29/26 at 1:45 P.M. interview with the DON revealed she did not realize there was an RSV outbreak until 04/22/26 when multiple residents were symptomatic and tested positive for RSV. The DON confirmed the facility failed to screen CNA #237 following her RSV positive test result and ongoing symptoms before permitting her to return to work and potentially spreading the RSV virus to other staff and residents. The DON further confirmed the facility did not have an effective RSV outbreak management plan in place.On 04/29/26 at 1:50 P.M. interview with the Administrator confirmed the RSV outbreak was not timely identified and the facility failed to have a comprehensive RSV outbreak management plan in place. The Administrator also verified the outbreak root cause was traced back to LPN #251 and CNA #237 both working despite their positive RSV test.On 05/05/25 at 11:23 A.M. interview with Nurse Practitioner (NP) #405 revealed she had not been involved in the development of an RSV policy and procedure following the identification of the current RSV outbreak and could not speak to any facility RSV policy. NP #405 revealed she did not recall initially being notified of RSV positive staff and stated she first became aware of the situation when Resident #66 tested positive for RSV following a hospitalization.On 05/06/26 at 10:15 A.M. interview with Medical Director/Physician #406 revealed he had not been directly involved with any RSV policy or procedure development and was only initially notified of resident cases. He stated he was unaware staff were the first to test positive. (See Findings at F880)b.Review of the facility's Plan of Correction for the citation at Data Tag F684 (from the Special Focus Facility Bi-annual survey dated 03/09/26) revealed beginning 03/16/26, the DON/Designee initiated random audits on a minimum of five residents with physician-ordered dietary or fluid restrictions weekly for four weeks and as needed thereafter. Audits included review of the signed communication forms to verify all applicable disciplines had acknowledged receipt of active orders; comparison of dietary records, nursing documentation, and the care plan to verify consistent implementation of ordered restrictions across all departments and shifts; and direct observation of meal service for affected residents to verify that fluid allotments are being implemented as ordered. Any issues identified within the audits would be forwarded to the Quality Assurance (QA) committee for immediate follow-up. The results of the audits would be reviewed during the QA meetings to determine if current action plan was effective or if additional interventions will need to be added.During the post-survey revisit completed on 05/15/26, Data Tag F684 was cited at a Severity Level 3 Actual Harm, with a scope and severity of G which indicated the deficiency was isolated but affected two residents, Resident #2 and #84. The facility failed to timely and appropriately identify a change in condition resulting in two emergent transfers and subsequent hospital admissions for the residents affected. (See Findings at F684). During the onsite survey, interview with the Administrator confirmed the most recent QAPI meeting was held as a quarterly meeting in February 2026. The Administrator confirmed the ongoing non-compliance identified for the facility and number of identified quality of care concerns. The Administrator revealed since Medical Director #406 began his new role in February 2026, the facility had not held a QAPI meeting and acknowledged the deficiencies at F684 and F880 were recites to the prior survey.The facility's QAPI policy was requested from the Administrator and Director of Nursing (DON) during the survey but was not provided.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, invoices, and interviews, the facility failed to ensure all electrical equipment was maintained in safe operating condition. This had the potential to affect all residents residing in the facility. The facility census was 38. Findings include: 1.Observation of the kitchen 02/23/26 at 8:08 A.M. with [NAME] #541 and [NAME] #531 revealed the walk-in refrigerator temperature log was over 41 degrees Fahrenheit (F) since 02/04/26 and had been taken out of use.The walk-in refrigerator was recorded at 50 degrees for the evening temperature on the 02/04/26 temperature log. To the right of the 50 degree F temperature, a temperature of 48 degrees was written and came to service was written. The temperature reading had been 40 degrees F recorded as the morning temperature on 02/02/26, 02/03/26 and 02/04/26. Interview on 02/25/26 at 4:13 P.M. with Dietary Manager #538 revealed she deleted her text and she cannot remember who texted her about the refrigerator being over temperature. She said she was told the temperature was in the 50's. She said she texted back and said get everything out of the cooler and put things in the reach-in refrigerator. She did not instruct the staff to take the temperature of any of the foods. They did not throw anything away. She said someone came to service the refrigerator but she had no paperwork and did not know who the person was. On 02/05/26, an evening temperature of 56 degrees F was recorded. On 02/06/26, an evening temperature of 54 degrees was recorded. There were no temperatures recorded for 02/07/26 or 02/08/26. On 02/09/26 the morning temperature was recorded at 58 degrees F. Interview on 02/26/26 at 2:11 P.M. with [NAME] #516 who was present on 02/04/26 revealed he opened the door to the refrigerator and the temperature was nicer in the walk-in than outside. He thought that was not a good sign. He texted Dietary Manager #538 and told her the temperature was in the 50's in the walk-in refrigerator. Items that would spoil were put in the reach in refrigerator. He had a conversation with the Dietary Manager #538 that the walk-in refrigerator was 40 degrees F three mornings in a row. Interview on 02/26/26 at 3:07 P.M. with the Administrator revealed he received a text at 9:45 A.M. on 02/08/26 about the walk-in refrigerator being 55 degrees F. He did not see the text on that Sunday morning and did not respond. He stated it was the first time he was informed that the walk-in refrigerator was not cooling. He did not know the temperature was 50 degrees F on 02/04/26 and he did not call a serviceman out on 02/04/26. He included he had no paperwork from any service repairman for 02/04/26. He verified there was a four-day delay in his notification of the walk-in refrigerator being broken. He verified reaching out to obtain a rental and repair the walk-in refrigerator was delayed five days.Interview on 02/26/26 at 3:22 P.M. with Maintenance #524 revealed he received a text at 7:30 P.M. on 02/08/26 that the walk-in refrigerator temperature was high. He stated it was the first time he was informed that the walk-in refrigerator was not cooling. He had no knowledge of the walk-in refrigerator not cooling on 02/04/26. He said if he knew the walk in was not cooling, he would have rented a rental unit sooner than 02/09/26. He verified there was a five-day delay in reaching out to get a rental unit and repair the walk-in refrigerator.2. Observation of the kitchen on 02/23/26 at 8:08 A.M. with [NAME] #541 and [NAME] #531 revealed the kitchen did not have a working oven. Both ovens became nonfunctioning between 01/30/26 and 02/05/26. The heating element of the oven on the right was welded to the bottom of the oven for approximately three weeks to one month related to a power surge.Interview 02/26/26 at 8:32 A.M. with Maintenance #524 revealed the oven that caught fire inside had welded the heating element to the bottom of the oven panel and was bought new in June 2025. The oven on the left was bought new in March of 2025. The oven bought in March 2025 had problems since it was bought and had not been working on-and-off since October 2025. He stated it was a lemon and the company did not want to stand behind the warranty, blaming the facility on not running the correct wattage of electricity to the oven. A new heating element was ordered for the oven. Interview 02/26/26 at 8:32 A.M. with the Administrator revealed on 03/06/26, the facility bought an oven with a new stove. On 06/09/25, a new stove with grill was bought. The Administrator stated there was too much power going from the breaker to the (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	ovens and it damaged them. He had an invoice dated 01/30/26 indicating both ovens were down and had been repaired. The invoice indicated the repairman had returned on 02/02/26 for electrical panel troubleshooting. On 02/10/26 the Administrator received a quote for a single deck convection oven with a removable door. 02/17/26, a heating element for the oven was ordered. The new oven was ordered and due for delivery around 03/16/26. This deficiency represents noncompliance investigated under Complaint Number 2788578.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 review of resident council minutes, review of concern forms, review of the facility's assessment and interview, the facility failed to maintain sufficient staffing to timely meet the total care needs of all residents. This affected ten residents (#1, #2, #4, #11, #14, #15, #22, #27, #28, and #47) of 38 residents residing in the facility. Review of Resident Council minutes dated 09/15/25 to 02/18/26 revealed old business resolved was resident had voiced concerns about how long it takes aides to find help using the Hoyer (mechanical lift). New concerns residents voiced included concerns about staff call offs and not having enough staff members available. An action plan was to provide education about call offs and scheduling. Additional staff provided to help residents' needs. During the meeting held on 11/17/25 and 12/15/25 resident's voiced concerns about food being served late. During the 12/15/25 meeting, residents present indicated food being served late was still going. The plan was to have mangers help pass trays, minimize residents down to two hallways, and interview with residents individually. Due to the relocation of residents to two facility hallways, during the meeting held on 01/20/26 concerns with food being served late was noted to be resolved. Review of facility concerns forms dated 09/16/25 to 02/23/26 and residents and family interview revealed the following staffing concerns: a. On 10/29/25 Resident #11 felt her call light was not answered timely. The recommended corrective action was to educate staff via [NAME] on the importance of responding to call lights as soon as possible or at least ensuring that staff members acknowledged a resident does have their light on and they would be assisted shortly. b. On 11/07/25 Resident #47 had concerns about call light response time. The recommended corrective action was education to be given to all nursing staff via [NAME] regarding the importance of responding to call lights promptly. c. On 12/08/25 Resident #4 had concerns with the call light response time. Residents were interviewed and the facility identified two residents to have problems. As a result, the facility recommended corrective action included educating staff on the importance of call light response time. d. On 12/10/25 Resident #11 voiced a concern about call light response time. Residents were interviewed and the majority of residents did not have any issues, however on the 200 hall there were two residents who had problems. As a result, the facility recommended corrective action included educating staff on the importance of call light response time. e. On 01/19/26 Resident #1 revealed difficulty locating a specific night-shift aide for approximately three hours. The facility determined the staff member was not assigned to the resident's unit. However, there was no evidence the facility resolved whether the resident's care needs were addressed based on a result of the concern and/or that staff was available to meet his needs during this timeframe. f. Interview with Resident #15's husband on 02/23/26 at 2:12 P.M. revealed that a few weeks ago, one staff person assisted the resident to the bathroom when there should have been two staff assisting with the use of a lift. He stated the resident fell in the bathroom with resulting bruising to her waist area. The husband attributed the incident to a lack of staff. During the interview, Resident #15's husband revealed staff were slow to answer the call light when his wife needed to use the bathroom. g. Interview on 02/23/26 at 10:24 A.M., with Resident #2 revealed there wasn't adequate staff on night shift. The resident reported there was only on certified aide for 19 residents and call lights were not answered timely. The waiting time for call lights can take up to an hour and one night she fell asleep after waiting over an hour. h. Interview on 02/23/26 at 1:59 P.M., with Resident #4 revealed staffing concerns indicating she had to wait 1.5 hours for ice water. The resident stated staff would answer the call light and say they would be back and they don't return timely. i. Interview on 02/25/26 at 11:10 A.M., with the Ombudsman revealed there was current concerns from residents regarding staffing shortage. j. Interview on 02/23/26 at 2:28 P.M., with Resident #14 revealed the facility needed more staff. The staff were too busy to help, and he had to wait for help to get off the floor (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	after sustaining a fall. k. Interview on 02/24/26 at 2:30 P.M., with Resident #1, #27, and #28 during a resident council meeting with the surveyor revealed the facility staffing concerns including the facility did not have adequate staffing on night shift. The residents reported they had to wait 30 minutes or longer for staff to answer the call lights. The residents voiced concerns that staff walk by the call lights or say they would be back and don't return. Resident #1 reported he needed a Hoyer lift to transfer and had to wait a long time for staff to get help to transfer him. Follow up interview on 02/25/26 at 9:40 A.M., with Resident #1 revealed the facility tells him when he reports staffing concerns they have more staff, but he states he doesn't see it. The resident reported that the staff on night shift were young and they stood around and goof off. The resident stated he had to wait to get out of bed because there wasn't enough staff available to operate the Hoyer lift to help him out of bed timely. Follow-up interview on 02/25/26 at 10:58 A.M., with Resident #27 revealed he had concerns with a lack of staff on night shift. The resident voiced concerns he had to wait a long time for staff to answer his call light timely. l. An interview during the survey with Anonymous Staff Member (ASM) #200 revealed concerns staff were not educated on staffing procedures. ASM #201 and #202 voiced concerns there were frequently not enough staff during the night shift. They indicated the facility scheduled three certified nursing assistants (CNA); however, there were usually only two who actually worked. The ASMs revealed there were several residents who required Hoyer lifts for transfers and there were several residents who required weights and showers on night shift which required additional staff to assist/help on the floor while the staff completed these tasks. In addition, the ASMs revealed several residents were night owls and didn't sleep on night shift and they requested food and snacks to be prepared which took extra time. The ASMs indicated staffing concerns/issues had been reported to management who were on call but very seldom did they come in to cover call offs. m. Review of self-reported incident (SRI) #270847 and investigation dated 02/12/26 revealed Resident #22 reported a concern regarding the care he received from Certified Nursing Assistant (CNA) #550. The resident stated his legs became numb after he had been seated on the toilet waiting for assistance from staff. The resident indicated he was not upset about the wait itself but felt that when the CNA entered the room, she displayed an unpleasant demeanor. The staff were educated on abuse prevention, appropriate resident interactions, and mandatory reporting requirements. Further review of the no evidence the resident concern regarding the wait time was investigated. The surveyor requested information; however, it was never provided.Interview on 02/25/26 at 7:06 A.M., with Resident #22 revealed he had activated his call light and had waited over 30 minutes in the bathroom, and his legs went numb, so he started yelling for help. The resident reported this was not the first time he had to wait over 30 minutes for staff to respond to his call light. The resident reported when the staff doesn't respond timely, he starts yelling until staff come.Interview on 02/25/26 at 7:23 A.M., with Certified Nursing Aide (CNA) #550 confirmed she was the CNA assigned to Resident #22 on 02/11/26. The CNA confirmed the resident had waited at least 20 minutes for help due to the other CNA assigned to the hall was on break and she was providing care to another resident. The housekeeper came and told the resident need assistance, but she could not leave the resident whom she was providing care to. The CNA confirmed she in the at least 20 minutes providing care to the other resident then she went to assist Resident #22. Interview on 02/25/26 at 11:10 A.M., with the Director of Nursing revealed she was aware there were concerns with staff on night shift and she had planned on making some night shift observations; however, that had not been completed as of this time. Review of the facility assessment dated [DATE] revealed there were 15-20 residents who required one to two staff assist and 15-20 residents who were dependent on staff. The direct care staff schedule included two licensed nurses on day and night shift, four CNAs on dayshift and three CNAs on night shift. As the census or centers needs change, to include resident acuity, staffing levels were adjusted accordingly. The assessment indicated residents and their family's input would be taken into consideration when making these decisions.Interview on 03/04/26 at 9:15 A.M. with Staffing Coordinator #503 revealed she scheduled (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff based on the census and tried to have two nurses and four CNAs on day shift and two nurses and three CNAs on night shift. If there was a call off, she stated she looked for coverage but felt with the current facility census they would be ok with only three CNAs on day shift and two CNAs on night shift.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident/representative interview, staff interview, policy review, record review, and review of binding arbitration agreements, the facility failed to ensure binding arbitration agreements were explained to residents/representatives in a manner that they understood and included an explanation that they were giving up the right to litigation in a court proceeding and could withdraw/terminate the agreement within 30 days after signing. This affected five residents (#2, #7, #10, #17, and #19) of six residents reviewed for arbitration agreements. The facility census was 38.Findings Include:The facility Administrator identified, with a list, that all 38 residents in the facility had signed a binding arbitration agreement. 1. Review of the record for Resident #7 revealed a readmission date of 11/25/25. A Minimum Data Set (MDS) assessment on 12/19/25 indicated a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. Review of a Binding Arbitration Agreement revealed it indicated Resident #7 had electronically signed (no actual signature) the agreement on 09/25/25. The staff member signing the agreement for the facility was Admissions Director #562. Interview with Resident #7 on 02/25/26 at 2:25 P.M. revealed he did not remember signing an arbitration agreement on 09/25/25. He stated he did not remember signing anything electronically and did not remember anything being explained to him as limiting his right to litigation in a court proceeding. 2. Review of the record for Resident #2 revealed an admission date of 04/28/25. A Minimum Data Set (MDS) assessment on 12/31/25 indicated a BIMS score of 13 indicating intact cognition. Review of a Binding Arbitration Agreement revealed it indicated Resident #2 had electronically signed (no actual signature) the agreement on 09/25/25. The staff member signing the agreement for the facility was Admissions Director #562. Interview with Resident #2 on 02/25/26 at 4:00 P.M. revealed she did not remember signing an arbitration agreement on 09/25/25. She stated she did not remember anything being explained to her as limiting her right to litigation in a court proceeding. 3. Review of the record for Resident #19 revealed an admission date of 02/10/26. A Minimum Data Set (MDS) assessment dated [DATE] revealed a BIMS test indicated a score of 12 indicating moderately impaired cognition. Review of a Binding Arbitration Agreement revealed it indicated Resident #19 had electronically signed (no actual signature) the agreement on 02/12/26. The staff member signing the agreement for the facility was Admissions Director #562. Interview with Resident #19 on 02/26/26 at 11:40 A.M. revealed he did not remember signing an arbitration agreement on 02/12/26. He stated he did not remember anything being explained to him as limiting his right to litigation in a court proceeding. He stated it would take two lawyers and a little kid to understand those kind of papers. 4. Review of the record for Resident #17 revealed an admission date of 02/09/26. Review of a Binding Arbitration Agreement revealed it indicated Resident #17's sister had electronically signed (no actual signature) the agreement on 02/12/26. The staff member signing the agreement for the facility was Admissions Director #562. Interview with Resident #17's sister on 03/02/26 at 9:49 A.M. revealed she had not been to the facility to sign any papers. She stated she might have talked to someone on the phone about admission papers but did not remember a binding arbitration agreement being discussed. She stated she was sick when the admission papers were discussed and she has been very overwhelmed by the whole admission process. She stated she would not have signed it, if it had been explained to her as limiting their right to litigation in a court proceeding. She was not aware that she had 30 days to withdraw or terminate agreement. She stated she would like to terminate the agreement. 5. Review of the record for Resident #10 revealed an admission date of 10/17/25. Review of a Binding Arbitration Agreement revealed it indicated Resident #10's daughter had electronically signed (no actual signature) the agreement on 10/21/25. The staff member signing the agreement for the facility was Admissions Director #562. Interview with Resident #10's daughter on 03/02/26 at 10:05 A.M. revealed she lived out of state and had not been to the (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility to sign any papers. She stated she had not had any conversations with anyone regarding admission paperwork. She stated there were some papers mailed through the mail to her and she was told it was required to sign. She stated she would not have signed the Binding Arbitration Agreement if it had been explained to her as limiting their right to litigation in a court proceeding. Interview with Admissions Director #562 on 02/26/26 at 8:20 A.M. revealed the Binding Arbitration Agreement is part of the facility admission packet. She stated that any resident with a BIMS score above 12 could sign the arbitration agreement. Otherwise, she talked to the family/representative about the arbitration agreement. She stated that she had been doing this since approximately December 2024. She stated that she used a laptop with the arbitration agreement already prepopulated in. She stated rarely did she have anyone decline to sign it. She stated that it required pushing a button on the laptop to electronically sign the arbitration agreement. When asked how she explained the arbitration agreement to residents/representatives, she stated that she explained that if their insurance did not pay, this kept it out of the court system. She stated she explained that you sit down to discuss the bill. She stated she explained that if their stay was not covered, this gave you the right, outside of court, to discuss without having to go to court and they are responsible for the bill if they didn't. She stated that was the [NAME] of what is said. She further stated that it was all about the bill/money. She stated she did not know if residents/responsible parties were able to withdraw or terminate the agreement within any certain time frame. She stated she did not know anything about who would be used as an arbitrator if one were to be used. Interview with Regional [NAME] President #579 on 02/26/26 at 9:30 A.M. revealed binding arbitration agreements were not to be a condition of admission. He confirmed residents/representatives should be able to withdraw/terminate an arbitration agreement within 30 days of signing. He confirmed that if an arbitration agreement was signed, the resident/representative would not be able to pursue litigation through the courts for issues such as injuries, wrongful death, property damage (as listed in the arbitration agreement). He confirmed the agreement should be explained well enough that they understand they can't pursue court litigation for the above items listed in the arbitration agreement. He stated education would be provided to the staff about having the arbitration agreements signed. Review of the facility policy dated November 2023 titled Binding Arbitration Agreements revealed residents (or their representatives) have the right to make informed decisions about important aspects of their health, welfare, and safety. Binding arbitration agreements are voluntary for the residents. Residents are not compelled, pressured, or coerced to enter into a binding arbitration agreement. The terms and conditions of a binding arbitration agreement are explained to the resident (or representative) in a way that ensures his or her understanding of the agreement, including that the resident may be giving up his or her right to have a dispute decided in a court proceeding (litigation). Residents are provided 30 days after signing to fully review and rescind any agreement not understood at the time of admission. Any facility personnel who are responsible for explaining the terms and conditions of binding arbitration agreements to the residents (or representatives) are trained in the specifics of this policy and in the requirements.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, policy review, and interview, the facility failed to ensure a resident was provided a dignified dining experience. This affected one resident (#6) of five residents observed for dining. The facility census was 38.Findings include: Review of Resident #6's medical record revealed a 01/28/25 admission with diagnoses including atrial fibrillation, hypertension, vascular dementia with behavioral disturbance, hypothyroidism, anemia, Vitamin D deficiency, vascular dementia, mood disturbance, depression, history of falling, insomnia, dysphagia, abnormalities of gait and mobility, long term use of anticoagulants, hypokalemia, muscle weakness and cognitive communication deficit. Review of the resident's Activity of Daily Living/Mobility plan of care included the resident required assistance related to weakness, and impaired mobility. Interventions included the resident will have needs anticipated and met by staff. Eating: Up to supervision/verbal cues with assist of one for task initiation and follow through initiated: 02/03/25 revision on: 12/17/25. Review of the 02/18/26 Quarterly Minimum Data Set Assessment (MDS) revealed the resident was severely impaired for daily decision making, had no dental issues, two falls since last assessment, adequate vision with no glasses, needed partial moderate assist with oral hygiene, supervision or touching assistance for eating. Observation on 02/23/26 at 11:50 A.M. of the lunch meal revealed Certified Nurse Aide (CNA) #551 revealed she stood over the resident's bedside and fed her the lunch meal. CNA #551 fed the resident her meal standing over the resident instead of sitting at her level. The resident was fed pureed fruit cocktail, chicken tortilla soup, broccoli and a ham sandwich. The resident was holding her coffee cup drinking from her cup of coffee independently. At the time of this observation, an attempt to interview the resident was unsuccessful as the resident was unable to answer questions appropriately. Interview on 02/23/26 at 12:34 P.M. with CNA #551 revealed the resident had been needing more help. CNA #155 verified she stood and fed the resident instead of sitting next to the resident and this was a dignity issue. Review of the facility policy, Assisting the Impaired Resident With in Room Meals, (revised September of 2013) included if you were going to be seated during the feeding position a chair where it will be convenient for you and the resident. The policy did not address standing while feeding a resident.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, policy review, and facility CQI/QA Assessment Tool review, the facility failed to ensure an allegation of neglect/mistreatment was reported to the State Survey Agency as required. This affected one resident (#15) of three residents reviewed for abuse/neglect/mistreatment. The facility census was 38.Findings include: Interview with Resident #15's husband on 02/23/26 at 2:12 P.M. revealed that a few weeks ago, one staff person assisted the resident to the bathroom when there should have been two staff assisting with the use of a lift. He stated the resident fell in the bathroom with resulting bruising to her waist area.Review of the medical record for Resident #15 revealed an admission date of 12/31/24 and diagnoses including chronic obstructive pulmonary disease, diabetes, cirrhosis of the liver, Crohn's disease, and vascular dementia.The resident had a physician's order dated 10/14/25 that stated the resident was to be a two person assist with the use of a sit to stand lift with a yellow sling (for transfers).Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a brief interview for mental status (BIMS) score of 13, indicating intact cognition. It further stated the resident was dependent upon staff for toileting, bed to chair transfers, toileting transfers, and had experienced one fall with no injury. A MDS assessment dated [DATE] revealed the resident had a BIMS score of 10, indicating moderately impaired cognition. It further stated the resident was dependent upon staff for toileting, bed to chair transfers, toileting transfers, and had experienced one fall with no injury. Review of the plan of care initiated 01/02/25 and revised 12/05/25 (after a fall) revealed Resident #15 was at risk for falls with or without injury related to anemia, impaired mobility, chronic pain syndrome, chronic disease progression, weakness, incontinence, decreased endurance related to chronic obstructive pulmonary disease, congestive heart failure, liver cirrhosis, vascular dementia, and status post fall. The goal was to minimize risk for falls to the extent possible. The interventions included using a sit to stand lift with yellow sling and two staff assistance.Review of a nursing progress note dated 12/19/25 at 4:57 P.M. by Director of Nursing (DON) #525 revealed on 12/19/25 at approximately 6:45 A.M. Resident #15 received assistance with toileting from nursing staff. The resident's roommate was present in the room and observed the care activity. Resident #4 (roommate) later reported that she noticed the staff member appeared to be working quickly as the shift was ending. She observed the resident being transferred to the toilet and noted the door remained open during the care. Resident #4 stated the resident sat down on the toilet and (the resident) made contact with the surrounding area during the transfer. The facility was notified of the incident at approximately 2:00 P.M. when the resident's family member called to discuss concerns about the morning care that was reported to him by the resident's roommate. Upon notification, the DON immediately initiated an assessment and investigation. Interviews were conducted with the roommate who provided the eyewitness information, the resident to the extent her cognitive abilities allowed, the family, and the staff member involved. Resident (#15) has cognitive impairment with a BIMS score of 9 related to diagnosis of vascular dementia and metabolic encephalopathy. When interviewed, the resident was able to communicate that she experienced some contact during her morning care routine and that she bumped her knees and head. She stated she did not feel the interaction was intentional and denied experiencing distress or fear. Due to her cognitive status and memory limitations, the resident was unable to provide detailed specifics about timing or sequence of events. Assessment findings included bruising to the right hip, left hand, left wrist, and right lower back. The medical provider was contacted and informed of the assessment findings and the resident's current medications including antiplatelet therapy (Plavix 75 milligrams daily). The provider ordered precautionary monitoring including neurological checks, x-ray, and laboratory studies. Based on the stable assessment findings and the resident's baseline status, transfer to the hospital was (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	determined to be unnecessary. Review of an interview statement from CNA #553 on 12/19/25 revealed he had helped Resident #15 with a transfer to the toilet around 6:45 A.M., which was near the end of his night shift. He acknowledged that he did a one-person manual transfer and did not use the sit-to-stand mechanical lift. He confirmed he was aware that her care plan stated she needed a sit-to-stand lift with two person assist for all transfers. He explained that it was near the end of his shift but he needed to finish his duties before 7:00 A.M. He said when he went to transfer Resident #15, he looked around and everyone looked busy with their own end of shift tasks. He said he did not want to bother anyone or ask them to stop what they were doing to help him, so he decided to do the transfer alone. He stated he knew the lift was to be used for safety reasons but admitted , at the time, he was focused on finishing his work before shift change. He stated he had helped the resident stand and turn towards the toilet. He initially said he did not think she hit anything with substantial force. But when told the resident reported bumping her knees and head, and that the assessment found bruising in several areas, he then acknowledged that she may have made contact with the toilet and surrounding area. He maintained he did not think the contact was very forceful or significant. He stated that he could not specifically remember but thought the door might have been open during toileting. He stated he did not report the incident or document it, because he did not feel the resident hit anything with substantial force and because she did not complain of pain right after the transfer. He stated he did not intend for her to get hurt and acknowledged that his decision to skip the mechanical lift was an error in judgement because he was feeling time pressure at the end of his shift. Review of the facility Continuous Quality Improvement/Quality Assurance assessment tool (investigation) revealed on 12/19/25 facility administration was made aware of an incident involving Resident #15 that occurred on the morning of 12/19/25 at approximately 6:45 A.M. The incident involved a transfer to the toilet that did not follow the resident's established plan of care requirements. The investigation stated that the resident's family requested that the resident no longer receive care from this particular staff member (CNA #553) and asked for follow-up to ensure this type of incident did not recur. The root cause analysis identified multiple contributing factors that led to this incident. The primary root cause was the staff member was working at the end of his shift (night shift ending at 7:00 A.M. and incident occurred at approximately 6:45 A.M.) and was rushing to complete resident care tasks before shift change. In an effort to save time, he made the decision to perform a one person transfer without using the required sit to stand mechanical lift, despite having knowledge that the resident's plan of care specifically required mechanical lift with two person assist for all transfers. This decision to cut corners and not follow the established plan of care directly resulted in the resident being transferred in a manner that did not provide adequate support and control, which caused her to contact the toilet and surrounding surfaces with greater force than would have occurred with proper mechanical lift use and two person assistance. The secondary root cause was the staff member demonstrated less than adequate knowledge and understanding of the critical importance of following the plan of care requirements even when experiencing time pressures or staffing constraints. The resident had multiple risk factors that necessitated strict adherence to mechanical lift use, such as being on Plavix (antiplatelet therapy) which made her highly susceptible to bruising from even minor contact with surfaces, having vascular dementia with poor impulse control and safety awareness, having generalized muscle weakness, psoriatic arthritis, and lack of coordination, and having a documented history of falls. Those risk factors made it even more critical that her transfer plan be followed precisely. Based on the investigation, this incident appeared to represent an isolated occurrence of a staff member making a poor decision under time pressure rather than widespread systemic failure. However, the incident did highlight the need for renewed education facility wide regarding the importance of following mechanical lift protocols, maintaining resident privacy, and understanding incident reporting requirements. The report stated that on 12/19/25 the DON/Designee provided comprehensive education to all nursing staff (RNs, LPNs, and CNAs) across all shifts regarding mechanical lift use, plan of care compliance, resident privacy rights, incident (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reporting requirements, and time management in relation to safety. The report stated all staff members that received this education signed an attendance record documenting their participation and understanding. There was no evidence the incident on 12/19/25 involving Resident #15 was self reported to the State Survey Agency. Interview with DON #525 on 02/26/26 at 10:30 A.M. revealed Resident #15's roommate (Resident #4) reported on 12/19/25 that Certified Nursing Assistant (CNA) #553 was a little too rough with Resident #15 (during care). The DON also indicated Resident #15 reported CNA #553 was a little rough during care. He was suspended following the report. She stated Resident #4 then retracted her statement that CNA #553 was rough. She stated Resident #15 had weakness and needed to have two staff and a sit to stand lift with transfers and CNA #553 did not use a lift and completed a resident transfer to the toilet by himself. The resident then went to sit down and hit hard on the toilet. Resident #4 indicated the resident hit her head on the wall. However, DON #525 stated Resident #15 denied hitting her head. (Neurological checks were done after the incident from 12/19/25 until 12/22/25 and were within normal limits). DON #525 stated when Resident #15 was assessed after the incident, she had bruising on her right hip, left hand, left wrist, and right lower back. The DON went on to say an x-ray of the left wrist was done due to minor complaints of pain. (x-ray results on 12/19/25 did not indicate a fracture) and after the investigation was completed, CNA #553 came back to work on a performance improvement plan and remained employed with the facility. Interview with the Administrator on 02/26/26 at 11:50 A.M. confirmed the incident involving Resident #15 where staff knowingly did not provide required care for the resident and Residents #4 and #15 initially reported staff being rough with care was not reported to the State Survey Agency. He stated it was not reported as the staff person involved (CNA #553) did not intend to hurt the resident. On 03/02/26 at 10:34 A.M. during interview DON #525 confirmed there were no measurements or descriptions of the bruising on Resident #15's right hip, left hand, left wrist, or right lower back after the incident on 12/19/25.Interview with Resident #15 on 03/02/26 at 9:05 A.M. revealed, when she was asked about the incident that occurred on 12/19/25, she stated she was so little and we both fell. (the staff person on 12/19/25 was a male). Interview with Resident #15's roommate (Resident #4) on 03/02/26 at 9:07 A.M. regarding the incident on 12/19/25 revealed a male aide (did not know name) came into the room and transferred Resident #15 to the bathroom by wheelchair. She stated the aide then had the resident stand (he was by himself and did not use a lift) and held onto the bar in the bathroom by the toilet. She stated the bathroom door was open. (observations revealed Resident #4 had a full view of the inside of the bathroom from her bed when the bathroom door was open). She stated the aide let go of Resident #15 and turned toward the sink. Resident #15 then fell hard onto the toilet. She stated the resident had bruising afterward. She did not see if the resident hit her head. She stated the aide acted like he did not want to be there. When asked why she felt this way, she stated it was his attitude and the way he walked. She stated she felt like her roommate was afraid of him but there had been no incidents since then.Review of the facility policy revised September 2022 and titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating revealed if resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the facility.

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	365780	A. Building B. Wing	03/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, record review and interview, the facility failed to ensure Minimum Data Set (MDS) assessments were accurately coded related to dental and vision. This affected two residents (#6 and #38) of 13 residents reviewed for accuracy of assessments.Findings include:1. Review of Resident #6's medical record revealed a 01/28/25 admission with diagnoses including atrial fibrillation, hypertension, vascular dementia with behavioral disturbance, hypothyroidism, anemia, Vitamin D deficiency, vascular dementia, mood disturbance, depression, history of falling, insomnia, dysphagia, abnormalities of gait and mobility, long term use of anticoagulants, hypokalemia, muscle weakness and cognitive communication deficit. Review of the 01/25/26 impaired visual function plan of care included the resident wears prescription glasses. Interventions included to keep glasses within reach of resident. Resident has impaired visual function. Resident wears prescription glasses, with history of conjunctivitis, and allergies. Review of the 01/25/25 dental plan of care included resident has oral/dental health problems. Resident is edentulous with upper and lower dentures. No complaint of pain or discomfort related to dentures. Monitor/document/report to physician as needed oral/dental problems needing attention. Review of the 01/25/25 Activity of Daily Living (ADL)/Mobility plan of care revealed the resident was at risk for ADL/mobility decline and requires assistance related to weakness, and impaired mobility. Review of the 12/31/25 Quarterly Minimum Data Set Assessment (MDS) included the resident had adequate vision no corrective lenses, broken or loosely fitting full or partial dentures (chipped, cracked, uncleanable, or loose), partial moderate assist for oral hygiene, substantial maximum support to roll, sitting, sit to stand and chair transfer, adequate vision with no glasses, needed partial moderate assist with oral hygiene, supervision or touching assistance for eating. Review of the 02/18/26 Quarterly Minimum Data Set Assessment (MDS) revealed the resident was severely impaired for daily decision making, had no dental issues, two falls since last assessment, adequate vision with no glasses, needed partial moderate assist with oral hygiene, supervision or touching assistance for eating. Interview on 02/23/26 at 1:55 P.M. with Resident #6's son revealed his mother is not putting in dentures. She complained they are not fitting. He revealed she wore reading glasses. Observation on 03/02/26 at 11:00 A.M. the resident did not have in dentures. She was handed the daily chronical and said she was not able to read the text. She was able to read the titles of each paragraph but not the paragraph itself which would put her in the impaired vision category without glasses. The resident said she did not know where her glasses were. Interview on 03/02/26 at 11:06 A.M. with Certified Nurse Aide (CNA) #551 revealed she has never tried to insert dentures for Resident #6 because she said she was not taught that the resident wears them. She found her dentures in the bathroom drawer and they were black with mold. When she tried to clean them she could not remove the mold. CNA #551 said the resident was not able to read. She had not known her to wear glasses. She was unable to find her glasses in the room. Interview on 03/02/26 at 12:39 P.M. with Registered Nurse (RN) #591 revealed maybe she changed the dental coding from broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose) on the December (25) MDS to no dental issue on the February (26) MDS because she was not wearing her dentures. She verified she did not update the plan of care for loose dentures or not wearing the dentures. For vision abilities, she asked the resident if she can see and also asked the staff. She did not have her read as directed by the MDS manual. She did not know the resident wore glasses or the plan of care said she had prescription glasses. Interview on 03/03/26 at 8:23 A.M. with Social Services (SS) #502 revealed he called the son who said she wore readers. He told him the strength. He went and got a pair of readers for the resident and she was able to read the daily /chronicle. Observation on 03/04/26 at 8:19 A.M. of Resident #6 revealed she was wearing readers reading the daily chronical and said she was happy she could read. 2. Review of Resident #38's medical record revealed a 11/15/23 admission with diagnoses including sensorineural hearing loss bilaterally, visual hallucinations, acute pyelonephritis, abnormalities of gait and mobility, diabetes mellitus, altered (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mental status, feeding difficulties, neuromuscular disfunction, need for assistance with personal care, dysphagia, anemia, iron deficiency anemia, chronic pain, hypokalemia, depression, retention of urine, presence of artificial hip joint, osteoarthritis, neuropathy, age-related nuclear cataracts bilaterally, dry eye syndrome, dementia, long term use of insulin, aspirin, antibiotics, and hypoglycemic drugs, history of methicillin resistant staphylococcus aureus, psychotic disturbance, mood disturbance, anxiety, hypothyroidism, Alzheimer's disease, cognitive communication deficit and muscle weakness. Review of a 01/25/24 Impaired Visual Function plan of care related to impaired peripheral vision, cataract bilateral, dry eyes bilateral, wears glasses, and wants surgery for cataracts (revised 10/09/25). A 04/28/25 Social Service note included new dentures received in mail today and given to the resident. A 08/25/25 dental note included no pain or discomfort. Review of the 02/10/26 Quarterly Minimum Data Set Assessment revealed the resident was moderately impaired for daily decision, dependent for lying to sitting and transfer, and substantial maximum assist for rolling in bed. The resident had no loose or ill fitting dentures. Her vision was adequate with glasses. She had upper and lower functional impairment bilaterally. The resident had two falls since the last assessment. The resident was on antidepressants, antibiotics, hypoglycemics. She was at risk for pressure ulcer but had no current pressure ulcers. The resident had a Oral/Dental Problems plan of care related to health condition, history of poor fitting dentures revised 02/13/2026. Encourage wearing of dentures and assist to clean after meals and as needed. Remove, store in labeled container and soak dentures nightly. Has upper and lower dentures. Interview and observation on 02/23/26 between 12:06 P.M. and 12:09 P.M. with Resident #38 revealed she can not see. She said she can not read the words in the song book at church. She included she saw the doctor who said she had cataracts. He said she needed cataract surgery but it was never done. Then a woman came and examined her eyes. She said she needs them out. Nothing happened. She stated her glasses are loose. The resident stated when she bites down her bottom dentures are loose. She can't wear them. She said I will tell them and I don't hear anything. The resident had glasses on and no dentures. Interview on 02/24/26 at 6:14 P.M. with the Director of Nursing and Administrator verified the resident has bilateral cataracts and she was to be referred to an Ophthalmologist for cataract removal. Interview on 02/25/26 at 9:03 A.M. with CNA #568 revealed the resident doesn't want to wear her dentures because they do not fit right. Interview on 02/25/26 at 1:41 P.M. with the resident revealed she was in activities for bible reading. She had a music book. She was unable to read the titles or the words of the songs with her glasses on. She said it was blurry which would be moderately impaired vision not adequate as stated in the MDS. Interview on 03/03/26 at 9:42 A.M. with RN #591 revealed she did not know the resident had dentures. She said the resident never told her although her dental care plan said she had loose fitting dentures. She was aware the resident had a history of bilateral cataracts. RN #591 verified the MDS dental section was coded incorrectly for loose dentures and vision.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview and policy review the facility failed to ensure care plans were revised to reflect current activities and discharge planning. This affected two (Resident #18 and #22) of 13 records reviewed. The facility census was 38. Findings include: 1.Record review revealed Resident #22 was admitted to the facility on [DATE] with diagnosis of acute and chronic respiratory failure with hypercapnia, obstructive sleep apnea, dependence of supplemental oxygen, congestive heart failure, morbid obesity due to excess calories, essential hypertension, iron deficiency anemia secondary to blood loss, nonalcoholic steatohepatitis, personal history of disease of the digestive system, anxiety, unsteadiness on feet, need for assistance with personal care, edema, muscle weakness, pain in unspecified knee, insomnia, unilateral primary osteoarthrosis, left knee, long term use of non-steroidal anti-inflammatory, gastro-esophageal reflux disease without esophagitis, and depression. Review of Resident #22 activity participation documentation dated 09/2025 to 02/2026 revealed in September 2025 the resident attended 25 group activities and refused one. In October 2025 the resident attended 19 group activities and refused six. In November 2025 the resident attended three group activities and refused eight. In December 2025 the resident attended four group activities and refused 11 group activities. In January 2026 the resident attended five group activities and refused seven. On January 17th one on one visits were added to the resident activity participation documentation. The resident had four one on one visits from 01/17/26 to 01/31/26. In February 2026 the residents participated in one group activity and refused six activities. He had seven one on one activities. Review of Resident #22's activities plan of care dated 03/21/25 revealed the resident was at risk for social isolation due to depression, prefers to stay in room, and social withdraw. Intervention includes to educate on the importance of social interactions, encouraging and assist in engagement in activities, encourage verbalize/communicate feelings, maintain daily activity routine, provide activity materials, introduce to peers who share similar interest, and reassure resident their safety and your respect for their wishes. There was no evidence of one-on-one visits. Interview on 02/26/26 at 10:25 A.M., with Activity Director (AD) #527 revealed Resident #22 had voiced concerns with increase depression and anxiety and he needed someone to talk to, so she added him to one-on-one visits recently. She sees him on Monday, and the Activity Assistant sees him on Saturday. The AD confirmed the one-on-one visits were not added to the resident plan of care. 2. Review of Resident #18's medical record revealed an admission date of 05/12/25 and diagnoses including development and epileptic encephalopathy, Lennox-Gastaut syndrome, severe intellectual disabilities, autistic disorder, other seizures, unspecified protein-calorie malnutrition, hyperlipidemia, major depressive disorder, bipolar disorder, and generalized anxiety disorder. Review of Resident #18's care plan revealed a care plan for discharge/transfer planning preference dated 10/20/25 that indicated the resident and resident's family preference was for long term care in the current facility. Care plan interventions initiated on 10/20/26 included the facility would identify and address barriers to discharge, the facility would provide an arena such as an interdisciplinary team (IDT) care conference for the resident, family and/or interested party to address plans for discharge and participate in the discharge planning process as indicated, the facility is to review the (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan of care initial/quarterly or as needed, social services is to document changes to discharge goal per the resident/resident representative preference as indicated, and social services is to schedule IDT care plan meetings upon admission, quarterly, and as needed. Further review of Resident #18's care plan revealed no information related to the facility working with the Department of Developmental Disabilities to move the resident back to the community. Review of Resident #18's quarterly Minimum Data Set(MDS) dated [DATE] revealed a brief interview for mental status score of four indicating the resident had severe cognitive impairment. Further review of the MDS revealed Resident #18 used a wheelchair for mobility, required supervision for eating, was dependent for bathing/showering and toileting hygiene, and required substantial/maximal assistance for bed mobility, and transfers. Resident #18 was frequently incontinent of bladder, always incontinent of bowel and had no skin issues such as pressure ulcers or skin tears. Review of Resident #18's progress notes revealed a note dated 01/07/26 at 8:50 A.M. written by Social Worker #502 that stated Social services called (the) resident's brother to remind him of the upcoming discharge meeting (scheduled for) today at 10:00 A.M. Review of Resident #18's progress notes revealed a late entry note dated 03/02/26 at 10:30 A.M. and entered on 03/03/26 at 10:31 A.M. written by Social Worker #502 that stated Social services and POA (Resident #18's power of attorney) went with (Resident #18's name) and person from [NAME] (Department of Developmental Disabilities) to visit a possible discharge location for (Resident #18's name). (Resident #18's name) seemed to really enjoy the place, (and was) not wanting to leave as they (the individuals at the location) started painting pictures. In an interview on 03/03/2026 at 1:13 P.M. Social Worker #502 confirmed the care plan for Resident #18's discharge had not been updated to reflect information related to the facility working with the Department of Developmental Disabilities to move the resident back to the community. Review of the policy titled Care Plans, Comprehensive Person Centered revised 03/2022 revealed assessments of residents are ongoing and care plans are to be revised as information about the resident and the resident's condition change.

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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. Based on observation, record review and interview, the facility failed to ensure a dependent resident was provided adequate and appropriate denture care. This affected one (Resident #6) of five residents reviewed for dental care. The facility census was 38. Findings include: Review of Resident #6's medical record revealed an admission date of 01/28/25 with diagnoses including atrial fibrillation, vascular dementia with behavioral disturbance, mood disturbance, depression, history of falling, insomnia, dysphagia (difficulty swallowing), abnormalities of gait and mobility, muscle weakness and cognitive communication deficit. Review of the 01/25/25 dental plan of care included the resident had oral/dental health problems. Resident is edentulous with upper and lower dentures. No complaint of pain or discomfort related to dentures. Monitor/document/report to physician as needed oral/dental problems needing attention. Review of the 01/25/25 Activity of Daily Living (ADL)/Mobiity plan of care revealed the resident was at risk for ADL/mobility decline and required assistance related to weakness, and impaired mobility. Review of the 02/18/26 Quarterly Minimum Data Set Assessment (MDS) revealed the resident was severely impaired for daily decision making, had no dental issues, needed partial moderate assist with oral hygiene, supervision or touching assistance for eating. Interview 02/23/26 at 1:55 P.M. with Resident #6's son revealed his mother wore dentures when she arrived to the facility in January 2025. He indicated she had not been wearing her dentures and she complained the dentures were not fitting. Observation and interview on 03/02/26 at 11:00 A.M. of Resident #6 revealed she was not wearing her dentures and she didn't know where the dentures were. The resident was not observed wearing dentures on 02/23/26, 02/24/26, 02/25/26, 02/26/26 or 03/02/26. Interview on 03/02/26 at 11:06 A.M. with Certified Nurse Aide (CNA) #551 revealed they had never tried the resident's dentures on her because the CNA was not taught that the resident wore dentures. The CNA found the dentures in the bathroom drawer and the dentures had a black substance noted on them. When the CNA tried to clean the dentures, she could not remove the substance. CNA #551 said she did not feel comfortable trying to put the dentures in the resident's mouth with how dirty they were. The CNA verified the staff were responsible for cleaning the resident's dentures and had not stored them clean. She verified the resident would not be able to wear them if she wanted due to not being cleaned. Observation 03/02/26 at 11:07 A.M. of the resident's dentures, located in the resident's bathroom, revealed the upper and lower dentures were covered with a black substance. On 03/05/26 at 1:25 P.M. the Administrator verified the facility did a deep cleaning of the resident's dentures and they were able to get them clean.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, and interview the facility failed to provide a comprehensive, resident centered activity program to meet resident needs. This affected one (Resident #22) of two residents reviewed for activities. The facility census was 38. Findings include: Record review revealed Resident #22 was admitted to the facility on [DATE] with diagnosis including obstructive sleep apnea, dependence of supplemental oxygen, congestive heart failure, morbid obesity due to excess calories, anxiety, unsteadiness on feet, need for assistance with personal care, muscle weakness, pain in unspecified knee, insomnia, unilateral primary osteoarthrosis, left knee, and depression. Review of consulting behavioral health note from the former consulting Licensed Social Worker #577 dated 08/01/25 revealed the resident was seen for anxiety, depression, mental health history, and substance use/recovery support. The resident was alert and oriented times four and open and cooperative. The resident was seen today for continuation of therapeutic support and pet therapy services. The resident reported he was experiencing fluctuation in mood, describing himself as feeling up and down. He acknowledged emotional difficulty with today being this providers final session, stating he was trying his best not to freak out. Despite this, the resident expressed that he feels he was continuing to make progress and takes steps forward. He continues to pursue a power chair to enhance his independence and remains engaged in facility life, including attending daily lunches in the dining room and participating in activities when able. The resident awareness of depressive symptoms, acknowledging a lack of motivation, but stated he was making efforts to leave his room [ROOM NUMBER]-2 times per day, even if only briefly. The resident thought process was logical, organized, and future oriented. Intervention included therapeutic support and reassurance, development and monitoring of behavioral health plans, and pet therapy.Review of ViaQuest TBS note dated 09/17/25 to 02/19/26 revealed Resident care plan objectives were to improve depression by engaging and increase social activities outside of the home evidenced by participating in two activities per week.Review of ViaQuest Therapeutic Behavior Service (TBS) note dated 11/14/25 revealed the resident reported that he has been to the dining room recently to eat but had not been to a group activity recently. Review of Resident #22's TBS note dated 12/09/25 revealed the resident was self-isolating in room and a decrease in hygiene. The resident self-reported that he had not been to an activity in a while Resident stated I don't really know why other than nothing looks like it is worth the effort it takes to get down there. Review of Resident #22's TBS note dated 12/11/25 revealed the resident was self-isolated and lack of hygiene. The resident self-reported that he still had not been to any activities. The resident had not been to the shower room as well. This is more than several weeks for not leaving his room.Review of Resident #22's annual MDS dated [DATE] revealed the residen'st cognition was intact. The resident had little interest or pleasure 12-14 days, feeling down, depressed, or hopeless, 12-14 days, trouble falling or staying asleep or sleeping too much 2-6 days, feeling tired or having little energy 12-14 days, feeling bad about yourself or that you are a failure or have let yourself or your family down 12-14 days, trouble concentration 7-11 days, moving or speaking so slowly that other people have noticed 2-6 days. Social isolation often. His behaviors included rejection of care 1 to 3 days. Activity preferences included personal belongings very important, snacks very important, bedtime very important, It was very important to listen to music. It is somewhat important to keep up with new, and do things with groups of people, and do favorite activities. It was very important to get fresh air. Review of TBS note dated 02/19/26 revealed the resident engaged in conversation about self-isolating and how he needed to go to activities as in the past it had improved his overall mood. Review of Resident #22 psychosocial-behavior plan of care dated 03/05/25 and revised on 10/15/25 revealed the resident had anxiety, depression, and insomnia. The residents frequently refused care such as bathing and weights. Interventions included to have activities assess for diversional activities, monitor behaviors, (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document and record behavioral episodes, encourage resident to verbalize feelings, maintain a calm, slow, understandable approach, and staff to encourage resident to bathe on scheduled shower days. Review of Resident #22's activities plan of care dated 03/21/25 revealed the resident was at risk for social isolation due to depression, prefers to stay in room, and social withdraw. Intervention includes to educate on the importance of social interactions, encouraging and assist in engagement in activities, encourage verbalize/communicate feelings, maintain daily activity routine, provide activity materials, introduce to peers who share similar interest, and reassure resident their safety and your respect for their wishes. Review of Resident #22 activity participation documentation dated 09/2025 to 02/2026 revealed in September 2025 the resident attended 25 group activities and refused one. In October 2025 the resident attended 19 group activities and refused six. In November 2025 the resident attended three group activities and refused eight. In December 2025 the resident attended four group activities and refused 11 group activities. In January 2026 the resident attended five group activities and refused seven. On 01/17/26, one on one visits were added to the resident activity participation documentation. The resident had four one on one visits from 01/17/26 to 01/31/26. In February 2026 the residents participated in one group activity and refused six activities. He had seven one on one activities. Review of the activity department schedule revealed the Activity Director worked Monday through Friday from 7:00 A.M. to 3:30 P.M., and the Activity Assistant worked Wednesday, Saturday, Sunday 9:30 A.M. to 3:00 P.M. and Thursday 9:30 A.M. to 6:30 P.M.Review of the activity calendars dated 09/2025 to 02/2026 revealed the activity calendar did not vary much month to month or day to day. Every day the first activity was the daily chronical 8:30 A.M. or 9:45 A.M., an activity at 10:00 A.M., 11:15 A.M. lunch bunch daily, and on Sundays at 2:00 P.M. was church, Monday 1:30 P.M. one on one with the Activities Director, Tuesday at 1:30 P.M. bingo, Wednesday at 1:30 P.M. bible college, Thursday 1:30 P.M. an activity with the activity aide or craft and at 5:00 P.M. a movie, Friday at 1:30 P.M. a party or self-directed activity, and Saturday bingo at 1:30 P.M. Other than Thursday's 5:00 P.M. move night all activities after 2:00 P.M. were self-directed (residents do activity on their own). Interview on 02/25/26 at 7:06 A.M., with Resident #22 revealed there were not too many activities appropriate for his age. The resident reported he could only color so many bunnies. The resident reported that Activity Director #527 wasn't at the facility all day and most of the activities in the evenings were self-directed. The resident reported he liked bingo, which the facility offered bingo twice a week. The resident reported he liked music, but the music performers that came in were for older people, not someone his age. The resident reported he would like to paint by numbers activity, but the facility didn't offer it. They used to play volleyball in the past, which the residents really liked but they have not done it recently. The facility doesn't offer too many outside activities which he liked as well. Interview on 02/26/26 at 10:25 A.M., with Activity Director (AD) #527 revealed the last schedule activity was usually around 1:30-2:00 P.M. except on Thursday which was movie night. The residents can do self-directed activities in the afternoon, and she had activities available in the activity room. The AD reported that most of the residents don't like group activities after 1:30 P.M., because they want to lie down, smoke, or they have therapy or other things going on. AD #527 reported that Resident #22 had voiced concerns with increased depression and anxiety and he needed someone to talk to, so she added him to one-on-one visits recently. She sees him on Monday, and the Activity Assistant sees him on Saturday. On the 02/16/25 she was on leave and did not provide one on one and on the 02/21/26 the Activity Assistant must have forgot to document her one on one. The AD confirmed the one-on-one visit was not added to the resident plan of care. The AD reported that the resident started to lose interest in activities when the 300-hall closed (January 2026) and he had to move to the 400 hall. He acts like he is interested in activities but doesn't attend after he says he was coming. He usually apologized to her and reported he couldn't get himself out. The AD reported the resident used to come down for lunch three times a week and bingo twice week. Follow up interview on 03/02/26 at 1:22 P.M. with AD confirmed the resident's activity participation had declined the last month. He had refused all group activity in the month of February 2026. His anxiety (continued on next page)

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	365780	A. Building B. Wing	03/09/2026

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and depression had increased and he slept more frequently. The AD reported the sign to leave the door open (on the door to the resident's room) had been there for about month or so. The AD reported she could recall an incident in January 2026 when the resident requested the door not be closed. The AD verified there were no activities specific to the resident's preferences or updates to determine the resident's preferences when the decline in the resident's activities was noted.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on record review and interview, the facility failed to provide ophthalmology services as ordered and assist the resident with the application of their glasses. This affected one (Resident #38) of four residents reviewed for vision. The facility census was 38. Findings include:Review of Resident #38's medical record revealed an admission date of 11/15/23 with diagnoses including sensorineural hearing loss bilaterally, visual hallucinations, abnormalities of gait and mobility, diabetes mellitus, need for assistance with personal care, age related nuclear cataracts bilaterally, dry eye syndrome, dementia, long term use of insulin, psychotic disturbance, anxiety, hypothyroidism, Alzheimer's disease, cognitive communication deficit and muscle weakness.Review of a 01/25/24 Impaired Visual Function plan of care related to impaired peripheral vision, cataracts bilateral, dry eyes bilateral, wears glasses, and wants surgery for cataracts was revised 10/09/25. Interventions included to keep glasses within reach of the resident. Resident has impaired visual function. Patient wears prescription glasses, with history of conjunctivitis, and allergies.Review of vision consult records revealed vision exam on 09/09/25. The Director of Nursing received the email with the consult on 10/17/25. The chief complaint was this female who comes in wanting to proceed with cataract surgery. The resident was previously referred (03/03/25) that referral was not followed through with, referring again today. Also, resident complaints of irritation in both eyes prescribing Restasis. The assessment included the resident had age-related nuclear cataract bilaterally. Dilated eye exam performed and resident has mature cataracts in both eyes and wants to proceed with cataract surgery. Referral filled out. Please see above fax number and fax the completed chart to the appropriate ophthalmology office. Facility is responsible for scheduling the appointment and the appropriate time frame mentioned above. Return visit in one month dry eye syndrome of bilateral lacrimal glands. Review of the 01/25/26 impaired visual function plan of care included the resident wears prescription glasses. Interventions included to keep glasses within reach of resident. Resident has impaired visual function. Patient wears prescription glasses, with history of conjunctivitis, and allergies.Review of a 02/09/26 360 Care Vision exam revealed the patient presents for evaluation of cataracts in the right eye and left eye. Condition is significant. Resident was assessed to have combined forms of age-related cataracts. Bilateral cataracts are visually significant. Please schedule for cataract evaluation with ophthalmologist of facility choice. Resident agrees to referral.Review of the physician orders revealed an order 02/09/26 to schedule an Ophthalmology consult. Review of the 02/18/26 Quarterly Minimum Data Set Assessment (MDS) revealed the resident was severely impaired for daily decision making, adequate vision with no glasses, needed partial moderate assist with oral hygiene, supervision or touching assistance for eating. Review of the medical record revealed there was not an ophthalmologist appointment scheduled after the 02/09/26 appointment as of 02/23/26.Review of the medical record revealed an ophthalmology appointment was scheduled for 05/04/26. This notation was made in the medical record on 02/24/26 at 5:12 P.M.Interview on 02/24/26 at 5:40 P.M. with the Director of Nursing revealed she did not know why there was not an Ophthalmologist appointment made after the 03/03/25 referral. She stated she did not get the results from the 09/09/25 vision appointment until 10/17/25.The DON stated the facility changed to a different vision provider for the 02/09/26 appointment due to receiving the ancillary consult referrals late from the previous provider. Interview 02/23/26 at 1:55 P.M. with Resident #6's son revealed his mother wore reading glasses. Interview with the Director of Nursing and Administrator on 02/24/26 at 6:14 P.M. verified they did not follow through with the Ophthalmology consult as previously recommended but the resident had an ophthalmology appointment scheduled for 05/04/26 for her bilateral cataracts.Interview on 02/25/26 at 4:57 P.M. with Medical Records Director (MRD) #585 revealed he scheduled resident appointments. He shared he was never notified in September or October the resident needed an ophthalmology appointment scheduled. He was not made aware of the resident needing an ophthalmology appointment after her 02/09/26 appointment. He said he was told (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	either late Friday, 02/20/23 or on Monday 02/23/26 that she needed an appointment scheduled. MRD #585 stated yesterday, 02/24/26 was his first chance to call and he received the May appointment date for Resident #38. Observation and interview 03/02/26 at 11:00 A.M. the resident did not have glasses on. The resident did not have glasses on when observed 02/23/26, 02/24/26, 02/25/26, 02/26/25, or 03/02/26. The resident did not know where her glasses were.Interview 03/02/26 at 11:06 A.M. with Certified Nurse Aide (CNA) #551 revealed the resident was not able to read. She had not known her to wear glasses and was unable to find her glasses in the room. She verified she was not applying glasses as per the plan of care.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to have pressure relieving devices (Prevalon boots) in place as ordered. This affected one resident (#38) of three residents reviewed for pressure ulcers. Findings Include: Review of Resident #38's record revealed an admission date of 11/15/23 with diagnoses including sensorineural hearing loss bilaterally, visual hallucinations, acute pyelonephritis, abnormalities of gait and mobility, diabetes mellitus, altered mental status, neuromuscular disfunction, need for assistance with personal care, chronic pain, presence of artificial hip joint, osteoarthritis, neuropathy, dementia, mood disturbance, anxiety, hypothyroidism, Alzheimer's disease, cognitive communication deficit and muscle weakness. Review of the Resident #38's care plan dated 03/31/24 revealed the resident had the potential for an alteration in skin integrity/pressure ulcers related to history of skin breakdown, immobility, incontinence, use of neck pillow while in bed, and diagnoses such as diabetes, anemia, hypothyroidism, and history of pressure ulcers. Interventions included to administer preventative treatments as ordered and monitor for effectiveness, and Prevalon boots (pressure relieving boots) to keep heels elevated off bed per physician order with instructions to remove every shift for skin checks and hygiene (initiated 03/31/24 and reordered 04/26/25). Review of Resident #38's hospital note dated 04/25/24 revealed the resident had pressure ulcers to the right heel stage 3 (indicating full thickness skin loss, a deep, crater-like ulcer where subcutaneous fat may be visible, but muscle, tendon, or bone are not exposed) and a pressure ulcer to the left heel stage 4 (indicating full thickness tissue loss, massive tissue loss with exposed muscle, tendon, or bone, often with undermining or tunneling). During the time of the survey, the resident's wounds had healed and the resident currently had no pressure ulcers of the heels. Review of the physician orders revealed an order dated 04/26/25 for Prevalon boots to be worn to bilateral feet at all times as tolerated with instructions for them to be removed for bathing/hygiene and every shift skin checks.Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed the resident was moderately impaired for daily decisions, dependent upon staff for lying to sitting and transfer, and required substantial maximum assistance for rolling in bed. The resident had upper and lower functional impairment bilaterally and was at risk for pressure ulcers but had no current pressure ulcers. Observation on 02/23/26 at 9:45 A.M. of Resident #38 revealed she was in bed on a pressure relieving mattress with bolsters. She did not have pressure relieving boots (Prevalon boots) on as ordered. At 11:50 A.M. the resident was up in a chair for lunch without Prevalon boots on. At 2:45 P.M., the resident remained up in the chair without Prevalon boots on. Observation on 02/24/26 at 1:51 P.M. revealed Resident #38 was in bingo, in her wheelchair with a Hoyer pad under her and her Preavlon boots were not on. Observation on 02/25/26 at 8:54 A.M. revealed Resident #38 was in bed, with a roll around her neck. She did not have Prevalon boots on as ordered. Interview on 02/25/26 at 9:03 A.M. with Certified Nurse Aide (CNA) #568 revealed she did not know anything about Resident #38 wearing Prevalon boots. She stated she had never put them on her. Interview on 02/25/26 at 9:23 A.M. with Licensed Practical Nurse (LPN) #532 revealed she did not know Resident #38 was supposed to have Prevalon boots on. She looked in the closet and bedside table and did not find any. LPN #532 verified the plan of care and physician orders included the use of Prevalon boots for pressure relief. The LPN verified the resident did not have Prevalon boots on and she was unable to locate any in the resident room.

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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 medical record review, interviews, employee file review, review of a facility investigation report and policy review the facility failed to provide adequate assistance and interventions to prevent injury during a transfer. The facility also failed to ensure fall prevention interventions were in place for a resident at risk for falls. This affected two residents (#15 and #31) of five residents reviewed for accidents. The facility census was 38.Findings included: 1. Review of the medical record for Resident #15 revealed an admission date of 12/31/24 with diagnoses including chronic obstructive pulmonary disease, diabetes, cirrhosis of the liver, Crohn's disease, and vascular dementia. Review of the plan of care initiated 01/02/25 and revised 12/05/25 (after a fall) revealed Resident #15 was at risk for falls with or without injury related to anemia, impaired mobility, chronic pain syndrome, chronic disease progression, weakness, incontinence, decreased endurance related to chronic obstructive pulmonary disease, congestive heart failure, liver cirrhosis, vascular dementia, and status post fall. The goal was to minimize risk for falls to the extent possible. The interventions included using a sit-to-stand lift (a motorized or hydraulic mobility device that helps partially weight bearing individuals transition from a sitting to a standing position) with yellow sling (color represented the size and in this case, medium) and two staff assistance (with transfers). A plan of care dated 01/03/25 revealed the resident was at risk for potential bleeding or bruising due to anticoagulant therapy secondary to atrial fibrillation. (Plavix 75 milligrams daily). An intervention included to monitor for bruising/bleeding. Review of the physician order dated 10/14/25 revealed the resident was to be a two person assist with the use of a sit to stand lift with a yellow sling (for transfers). A plan of care dated 10/20/25 revealed the resident had alterations in skin and was at risk for delayed healing and infection. An intervention included handling gently during activities of daily living. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a brief interview for mental status (BIMS) score of 13 out of a possible 15, indicating intact cognition. It further stated the resident was dependent upon staff for toileting, bed to chair transfers, toileting transfers, and had experienced one fall with no injury during the assessment period. Review of a nursing progress note dated 12/19/25 at 4:57 P.M. by Director of Nursing (DON) #525 revealed on 12/19/25 at approximately 6:45 A.M. Resident #15 received assistance with toileting from nursing staff. The resident's roommate was present in the room and observed the care activity. Resident #4 (roommate) later reported that she noticed the staff member appeared to be working quickly as the shift was ending. She observed the resident being transferred to the toilet and noted the door remained open during the care. Resident #4 stated the resident sat down on the toilet and (the resident) made contact with the surrounding area during the transfer. The facility was notified of the incident at approximately 2:00 P.M. when the resident's family member called to discuss concerns about the morning care that was reported to him by the resident's roommate. Upon notification, the DON immediately initiated an assessment and investigation. Interviews were conducted with the roommate who provided the eyewitness information, the resident to the extent her cognitive abilities allowed, the family, and the staff member involved. Resident (#15) has cognitive impairment with a BIMS score of 9 related to diagnosis of vascular dementia and metabolic encephalopathy. When interviewed, the resident was able to communicate that she experienced some contact during her morning care routine and that she bumped her knees and head. She stated she did not feel the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interaction was intentional and denied experiencing distress or fear. Due to her cognitive status and memory limitations, the resident was unable to provide detailed specifics about timing or sequence of events. Assessment findings included bruising to the right hip, left hand, left wrist, and right lower back. The medical provider was contacted and informed of the assessment findings and the resident's current medications including antiplatelet therapy (Plavix 75 milligrams daily). The provider ordered precautionary monitoring including neurological checks, x-ray, and laboratory studies. Based on the stable assessment findings and the resident's baseline status, transfer to the hospital was determined to be unnecessary. Review of the facility investigation revealed the following: Review of an interview statement from CNA #553 on 12/19/25 revealed he had helped Resident #15 with a transfer to the toilet around 6:45 A.M., which was near the end of his night shift. He acknowledged that he did a one-person manual transfer and did not use the sit-to-stand mechanical lift. He confirmed he was aware that her care plan stated she needed a sit-to-stand lift with two person assist for all transfers. He explained that it was near the end of his shift but he needed to finish his duties before 7:00 A.M. He said when he went to transfer Resident #15, he looked around and everyone looked busy with their own end of shift tasks. He said he did not want to bother anyone or ask them to stop what they were doing to help him, so he decided to do the transfer alone. He stated he knew the lift was to be used for safety reasons but admitted , at the time, he was focused on finishing his work before shift change. He stated he had helped the resident stand and turn towards the toilet. He initially said he did not think she hit anything with substantial force. But when told the resident reported bumping her knees and head, and that the assessment found bruising in several areas, he then acknowledged that she may have made contact with the toilet and surrounding area. He maintained he did not think the contact was very forceful or significant. He stated that he could not specifically remember but thought the door might have been open during toileting. He stated he did not report the incident or document it, because he did not feel the resident hit anything with substantial force and because she did not complain of pain right after the transfer. He stated he did not intend for her to get hurt and acknowledged that his decision to skip the mechanical lift was an error in judgement because he was feeling time pressure at the end of his shift. Review of the facility Continuous Quality Improvement/Quality Assurance assessment tool (investigation) revealed on 12/19/25 facility administration was made aware of an incident involving Resident #15 that occurred on the morning of 12/19/25 at approximately 6:45 A.M. The incident involved a transfer to the toilet that did not follow the resident's established plan of care requirements. The investigation stated that the resident's family requested that the resident no longer receive care from this particular staff member (CNA #553) and asked for follow-up to ensure this type of incident did not recur. The root cause analysis identified multiple contributing factors that led to this incident. The primary root cause was the staff member was working at the end of his shift (night shift ending at 7:00 A.M. and incident occurred at approximately 6:45 A.M.) and was rushing to complete resident care tasks before shift change. In an effort to save time, he made the decision to perform a one person transfer without using the required sit to stand mechanical lift, despite having knowledge that the resident's plan of care specifically required mechanical lift with two person assist for all transfers. This decision to cut corners and not follow the established plan of care directly resulted in the resident being transferred in a manner that did not provide adequate support and control, which caused her to contact the toilet and surrounding surfaces with greater force than would have occurred with proper mechanical lift use and two person assistance. The secondary root cause was the staff member demonstrated less than adequate knowledge and understanding of the critical importance of following the plan of care requirements even when experiencing time pressures or (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staffing constraints. The resident had multiple risk factors that necessitated strict adherence to mechanical lift use, such as being on Plavix (antiplatelet therapy) which made her highly susceptible to bruising from even minor contact with surfaces, having vascular dementia with poor impulse control and safety awareness, having generalized muscle weakness, psoriatic arthritis, and lack of coordination, and having a documented history of falls. Those risk factors made it even more critical that her transfer plan be followed precisely. Based on the investigation, this incident appeared to represent an isolated occurrence of a staff member making a poor decision under time pressure rather than widespread systemic failure. However, the incident did highlight the need for renewed education facility wide regarding the importance of following mechanical lift protocols, maintaining resident privacy, and understanding incident reporting requirements. The report stated that on 12/19/25 the DON/Designee provided comprehensive education to all nursing staff (RNs, LPNs, and CNAs) across all shifts regarding mechanical lift use, plan of care compliance, resident privacy rights, incident reporting requirements, and time management in relation to safety. The report stated all staff members that received this education signed an attendance record documenting their participation and understanding. However, review of staff attendance records for 12/19/25 regarding education on mechanical lift use, plan of care compliance, resident privacy rights, incident reporting requirements, and time management in relation to safety revealed only six of 24 nursing assistants, six of 14 LPNs, and one of three RNs had signed the attendance records documenting their participation and understanding. (The facility provided a list of staff who were employed by the facility on 12/19/25 which was used to determine what staff worked at the facility during that time compared to who had signed the attendance records). Interview with Resident #15's husband on 02/23/26 at 2:12 P.M. revealed a few weeks ago, one staff person assisted the resident to the bathroom when there should have been two staff assisting with the use of a lift. He stated the resident fell in the bathroom with resulting bruising to her waist area. The husband provided no additional information. Interview with DON #525 on 02/26/26 at 10:30 A.M. revealed Resident #15's roommate (Resident #4) reported on 12/19/25 that Certified Nursing Assistant (CNA) #553 was a little too rough with Resident #15 (during care). The DON also indicated Resident #15 reported CNA #553 was a little rough during care. He was suspended following the report. She stated Resident #4 then retracted her statement that CNA #553 was rough. She stated Resident #15 had weakness and needed to have two staff and a sit to stand lift with transfers and CNA #553 did not use a lift and completed a resident transfer to the toilet by himself. The resident then went to sit down and hit hard on the toilet. Resident #4 indicated the resident hit her head on the wall. However, DON #525 stated Resident #15 denied hitting her head. (Neurological checks were done after the incident from 12/19/25 until 12/22/25 and were within normal limits). DON #525 stated when Resident #15 was assessed after the incident, she had bruising on her right hip, left hand, left wrist, and right lower back. The DON went on to say an x-ray of the left wrist was done due to minor complaints of pain. (x-ray results on 12/19/25 did not indicate a fracture) and after the investigation was completed, CNA #553 came back to work on a performance improvement plan and remained employed with the facility. Interview with Resident #15 on 03/02/26 at 9:05 A.M. revealed, when she was asked about the incident that occurred on 12/19/25, she stated she was so little and we both fell. (the staff person on 12/19/25 was a male). Interview with Resident #15's roommate (Resident #4) on 03/02/26 at 9:07 A.M. regarding the incident on 12/19/25 revealed a male aide (did not know name) came into the room and transferred Resident #15 to the bathroom by wheelchair. She stated the aide then had the resident stand (he was (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by himself and did not use a lift) and held onto the bar in the bathroom by the toilet. She stated the bathroom door was open. (observations revealed Resident #4 had a full view of the inside of the bathroom from her bed when the bathroom door was open). She stated the aide let go of Resident #15 and turned toward the sink. Resident #15 then fell hard onto the toilet. She stated the resident had bruising afterward. She did not see if the resident hit her head. She stated the aide acted like he did not want to be there. When asked why she felt this way, she stated it was his attitude and the way he walked. She stated she felt like her roommate was afraid of him but there had been no incidents since then. On 03/02/26 at 10:34 A.M. interview with DON #525 confirmed there were no measurements or descriptions of the bruising on Resident #15's right hip, left hand, left wrist, or right lower back after the incident on 12/19/25. An attempt was made to interview CNA #553 on 02/26/26 at 3:08 P.M. There was no answer and a voicemail was left. He did not return the call. Review of CNA #553's employee file revealed he had been trained on mechanical lift use on 09/03/24. Interview with the Administrator and DON #525 on 03/02/26 at 8:45 A.M. revealed they had lost the original staff education attendance records completed on 12/19/25 (however, this was not noted in the investigation). They stated they had gone back and had some staff sign the attendance records between 01/28/26 and 02/06/26. However, not all the staff that worked at the facility on 12/19/25 still worked at the facility now, so signatures were not able to be obtained. They confirmed there was no evidence that all nursing staff (RNs, LPNs, and nursing assistants) had been educated after the incident with Resident #15 on 12/19/25. Review of the facility policy revised July 2017 and titled Lifting Machine, Using a Mechanical revealed at least two nursing assistants are needed to safely move a resident with a mechanical lift. Mechanical lifts may be used for tasks that require: transferring a resident from bed to chair; toileting or bathing. Types of lifts that may be available in the facility are: sit-to-stand lifts. 2. Review of Resident #31's medical record revealed an admission date of 08/09/24 and diagnoses including atrial fibrillation, dementia, chronic obstructive pulmonary disease, chronic respiratory failure, persistent mood disorder, hypertension, and cardiomegaly. Review of Resident #31's fall risk care plan, initiated on 08/19/24 and revised on 12/17/25, revealed the resident had a history of falls and was very impulsive and unable to retain education after a fall. Resident #31's fall interventions included: call light to be accessible when the resident was in the room, initiated on 08/19/24 and revised on 01/07/26, anti-roll backs to his wheelchair and encourage resident to wear hipsters to prevent injury from falls. Review of Resident #31's quarterly Minimum Data Set (MDS) dated [DATE] revealed a brief interview for mental status score of 05, out of a possible score of 15, indicating the resident had severe cognitive impairment. Further review of the MDS revealed Resident #31 used a wheelchair for mobility, required substantial/maximal assistance with showering/bathing and bed mobility, was dependent on staff for toileting hygiene and for transfers, was always incontinent of bladder and frequently incontinent of bowel and had one fall without injury since the previous MDS was completed. An observation on 02/25/26 at 4:20 P.M. revealed Resident #31 was resting in bed. Resident #31's right side of the bed was against the wall and the head of the bed by the window. The resident's call (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	light cord was connected to the wall but the call light button was not visible or noted to be within the resident's reach. An observation and interview on 02/25/26 at 4:25 P.M. with Certified Nursing Assistant (CNA) #505 verified the call light button was not accessible to the resident. The CNA moved pillows that were located at the foot of the bed and confirmed the call light button was located under the pillows and out of the reach of Resident #31. The CNA verified this was a fall prevention intervention to have the call light within the resident's reach.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview, observation, and policy review, the facility failed to ensure oxygen use was documented and humidification was provided per the resident's plan of care. This affected two (Resident #3 and #37) of two reviewed of respiratory care. Findings Include: 1. Review of Resident #37's medical record revealed Resident #37 was admitted to the facility on [DATE] with diagnoses including abnormal findings of lung fields, nicotine dependence, edema, chronic obstructive pulmonary disease, anxiety, chronic respiratory failure, and palliative care. Review of Resident #37's oxygen plan of care dated 10/15/25 revealed to administer oxygen per order and change humidification and oxygen tubing as indicated. Review of Resident #37's Minimum Data Set (MDS) assessment dated [DATE] reflected oxygen use. Review of Resident #37's Medication and Treatment administration record dated 02/02/26 revealed an order for oxygen four liters via nasal cannula every four hours as needed for shortness of breath. There was no documented evidence the oxygen was signed off as administered for the entire month of February 2026. Observation on 02/23/26 at 11:21 A.M. revealed Resident #37's humidification bottle was empty and dated 02/06/26. The resident had oxygen on and set at 3.5 liters. Observation on 02/24/26 at 10:55 A.M. revealed Resident #37's humidification bottle was empty and dated 02/06/26. The resident had oxygen on and set at 3.5 liters. Observation on 02/25/26 at 7:19 A.M., revealed Resident #37's humidification bottle was empty and dated 02/06/26. The resident had the oxygen on and set at 4 liters. Interview on 02/25/26 at 7:19 A.M., with Licensed Practical Nurse (LPN) #543 confirmed Resident #37's oxygen humidification bottle was empty and dated 02/06/26. The LPN also confirmed the resident had oxygen on and running at four liters and the oxygen was not signed off of the administration record. The LPN confirmed the residents had oxygen on Monday and Tuesday as well and it was not signed off the administration record as administered. LPN #543 was the residents nurse Monday (02/23/26), Tuesday (02/24/26), and Wednesday (02/25/26). Interview on 02/25/26 at 11:47 A.M., with Resident #37 confirmed staff had added humidification to her oxygen and her nose and mouth dryness had improved. The resident was observed with her oxygen on. Review of the facility policy titled Oxygen Administration dated 2001 revealed to check the mask, tank, humidifying jar, etc., to be sure they are in good working order and are securely fastened. Be sure there is water in the humidifying jar and that the water level is high enough that the water bubble as oxygen flows through. Periodically re-check water level in humidifying jar. 2. Review of Resident #3's medical record revealed an admission date of 09/10/12, a re-entry date of 03/11/18, a hospital stay starting on 01/20/26, returning on 01/23/26, and diagnoses including acute and chronic respiratory failure with hypoxia and hypercapnia, chronic obstructive pulmonary disease with acute exacerbation, asthma, paranoid schizophrenia, unspecified psychosis, bipolar disorder, (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	extrapyramidal and movement disorder, diabetes, dementia, and hypertension. Review of Resident #3's five-day Minimum Data Set (MDS) assessment dated [DATE] revealed a brief interview for mental status score of 08 indicating the resident had moderate cognitive impairment. Further review of the MDS revealed the resident required supervision or touching assistance for toileting hygiene, partial/moderate assistance for showering/bathing, was independent with bed mobility and transfers, was frequently incontinent of bladder and always continent bowel and was receiving oxygen therapy. Review of Resident #3's physician's orders revealed an order dated 01/23/26 for continuous oxygen at two liters per minute via nasal cannula. Review of Resident #3's progress notes revealed a note dated 01/23/26 at 5:59 P.M. written by Licensed Practical Nurse (LPN) #543 indicating Resident #3 returned from the hospital on two liters of oxygen. Review of Resident #3's progress notes revealed a note dated 02/22/26 at 7:15 P.M. written by Registered Nurse (RN) #549 indicating the resident was on the floor right outside of her room door, laying on her left side with no injuries observed. Resident #3's oxygen was not on at the time of the fall as the resident was trying to get the oxygen tubing untangled from her wheelchair. Further review of Resident #3's progress notes revealed no further documentation by licensed nursing floor staff of Resident #3's oxygen use. Review of Resident #3's medication and treatment administration records for February 2026 revealed no documentation on the orders that the resident was receiving continuous oxygen at two liters per minute via nasal cannula. In an interview on 03/03/26 at 3:40 P.M. the Regional Director of Clinical Services (RDCS) #578 confirmed Resident #3 had an order for continuous oxygen at two liters per minute via nasal cannula and that there was no documentation on the medication or treatment administration record of the oxygen being delivered.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on record review, observation, and interview, the facility failed to ensure dialysis residents fluid restrictions were accurate and implemented timely. This affected two (Resident #2 and #11) of two reviewed for dialysis. Findings Include: 1. Medical record review revealed Resident #2 was admitted to the facility 04/28/25 with diagnoses including dependence of renal dialysis, end stage renal disease, and heart disease. Review of Resident #2's nutritional recommendation dated 02/26/26 revealed a 1500 milliliter (ml) fluid restriction with instructions for nursing to administer 780 ml and dietary to administer 720 ml (240 ml with breakfast, lunch, and dinner). Review of Resident #2's nutritional plan of care dated 04/30/25 and revised on 03/02/26, and dehydration plan of care dated 04/29/25 and revised on 03/02/26, revealed a 1500 ml fluid restriction with instructions for dietary to serve 1080 ml (breakfast: 480 ml, lunch: 240 ml, and dinner: 360 ml) and nursing to administer 420 ml (7-3 shift: 200 ml, 3-11 shift: 120 ml, and 11-7 shift: 100 ml). Review of Resident #2's dialysis plan of care dated 09/17/25 revealed to monitor intake and output. Review of Resident #2's current orders revealed on 02/27/26, a new order was received for 1500 ml fluid restriction with instructions for dietary to serve 1080 ml (breakfast: 480 ml, lunch: 240 ml, and dinner: 360 ml) and nursing to administer 420 ml (7-3 shift: 200 ml, 3-11 shift: 120 ml, and 11-7 shift: 100 ml). On 03/02/26 an additional order was added for a 1500 ml fluid restriction with instructions for the resident to receive 360 ml at breakfast, 240 ml at lunch, and 360 ml at dinner and dayshift nursing to administer 270 ml and night shift 270 ml. Review of Resident #2's medication and treatment administration record dated March 2026 revealed dietary to serve 1080 ml (breakfast: 480 ml, lunch: 240 ml, and dinner: 360 ml) and nursing to administer 420 ml (7-3 shift: 200 ml, 3-11 shift: 120 ml, and 11-7 shift: 100 ml). On 03/01/26 the resident received 1520 for the day and on 03/02/26 the resident received 460 plus (there was no accurate amount recorded). Further review of the administration record revealed on 03/02/26 an additional order was added for a 1500 ml fluid restriction. The resident was to receive 360 ml at breakfast, 240 ml at lunch, and 360 ml at dinner and dayshift nursing to administer 270 ml and night shift 270 ml. Staff signed off the fluid restriction however didn't include the intake amount. Interview on 03/03/26 at 2:23 P.M., with the Director of Nursing (DON) confirmed the resident had two different active fluid restriction orders entered and staff were signing off they administered both orders that were not consistent with the dietician order. The DON confirmed staff should follow the recommendations from the dietician. The DON reported she had entered the second order on 03/02/26, however confirmed it did not match the recommendations from the dietician. 2. Review of Resident #11's medical record revealed an admission date of 12/05/20 with diagnoses including dependence of renal dialysis, end stage renal disease, chronic hypoxemic respiratory failure, cardiovascular accident, neurogenic urinary bladder, left ventricular diastolic dysfunction, chronic respiratory failure, morbid obesity, hyponatremia, and hypothyroidism. Review of Resident #11's care plan dated 01/15/24 revealed the resident was at risk for fluid (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	imbalance related to end stage renal disease (ESRD) and was on dialysis. Interventions included to remain free of signs and symptoms of fluid overload, in or absence of edema, anxiety, agitation, restlessness, confusion, changes in mood or behavior, nausea, vomiting, dyspnea, congestion, orthopnea, easily fatigued, and jugular vein distension. Review of Resident #11's 02/05/25 Quarterly Minimum Data Set Assessment included the resident was independent for daily decision making and the resident had a weight gain. Review of Resident #11's nutrition narrative note dated 02/26/26 at 11:50 A.M. included the dietitian received information from the dietitian at the dialysis center reporting that the target weight had been changed to 188.8 pounds. Interdialytic weight gains were high at times, and a fluid restriction had been recommended for 1500 milliliters (ml) every day. It noted the residents phosphorus remained high and the resident didn't want to take more than one binder per meal. The risk and consequences of high phosphorus levels had been reviewed with the resident with verbalized understanding. It noted a recommendation for a 1500 ml fluid restriction. Review of Resident #11's nutritional recommendation dated 02/26/26 revealed a 1500 milter (ml) fluid restriction with instructions for nursing to administer 780 ml and dietary to administer 720 ml (240 ml with breakfast, lunch, and dinner). Review of Resident #11's physician orders on 03/02/26 revealed the resident was not placed on the 1500 cc fluid restriction. She was on a renal diet regular texture with thin liquids. Observation and interview on 03/02/26 at 4:31 P.M. of Resident #11's meal ticket revealed she was not on a fluid restriction. The resident received eight ounces of lemonade and eight ounces of hot tea for a total of 480 ml of fluid for supper. She indicated she had no knowledge of a fluid restriction. Interview on 03/02/26 at 4:48 P.M. with Certified Nurse Aide (CNA) #48 revealed Resident #11 was not on a fluid restriction. He double checked in the kiosk and said it was not in his information that she was to be restricted with fluids. Interview on 03/02/26 at 4:55 P.M. with the Director of Nursing (DON) revealed the dietician did not send the recommendations until after hours. She stated she was not at the facility the day they would have been emailed to her and her team. She would need to look at her emails from the dietician to see the recommendations. Further review of Resident #11's physician orders on 03/02/26 revealed now an order was entered for the fluid restriction for a 1500 mL fluid restriction: 780 mL for nursing and 720ml for dietary: 240 ml for breakfast, 240ml for lunch, and 240 for dinner. Interview on 03/03/26 at 9:12 A.M. with the DON verified no one looked at the email sent by the dietician with the recommendations. The DON added she received the email as well as her unit manager, and a contract company employed the dietician. She would have received the email on 02/27/26. She stated she was busy with the survey and received so many emails, the recommendations were missed.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, facility assessment review and interview the facility failed to ensure a comprehensive, trauma-informed approach to care was implemented for a resident with post-traumatic stress disorder (PTSD). This affected one resident (Resident #22) of three residents reviewed for behaviors.Findings include:|Record review revealed Resident #22 was admitted to the facility on [DATE] with diagnosis including anxiety, need for assistance with personal care, insomnia, and depression. There was no diagnosis of PTSD listed on the resident diagnoses list. Review of the resident's hospital Discharge summary, dated [DATE] and authored by Medical Doctor (MD) #900, revealed Resident #22 did have some mention of depression due to his current situation, and he was seen in consultation by neuropsychology with impression and recommendation as follows: patient describes longstanding history of recurrent depression which has been only recently addressed. He also reports increased anxiety. The resident had a longstanding history of post-traumatic stress disorder (PTSD) which has also never been formally treated or addressed. He is currently being treated from a psychopharmacological standpoint with bupropion (anti-depressant) 300 milligram (mg) daily, Zoloft (anti-depressant) 100 mg daily and trazadone (anti-depressant) 100 mg nightly. The hospital discharge summary included the MD strongly recommended outpatient follow-up with psychiatry for ongoing monitoring and management of psychiatric condition. The resident would also benefit from outpatient counseling and stated he had initiated the process prior to hospitalization. MD #900 recommended case management to work with him to confirm he does in fact have outpatient follow-up for mental health service. Outpatient mental health services would be helpful in both managing the resident's depression and anxiety as well as monitoring sobriety. Continued review of the hospital discharge summary revealed the resident was independent for oral hygiene and upper body dressing, required (staff) set-up assistance with bathing himself and toilet transfer. Resident #22 required (staff) partial/moderate assistance to brush hair, shower, and transfer, substantial to maximum (staff) assistance with lower body dressing and was dependent on staff for toileting hygiene. In terms of his cognition and communication, the resident was independent for all tested tasks. The resident was stable to discharge. Review of Resident #22's admission social service assessment authored by Social Service Designee (SSD) #502 dated 12/12/24 revealed the resident had a drug history and previous psychological or psychiatric intervention. The resident reported he was in a psychiatric hospital in 9th grade but couldn't remember the name. The resident reported he struggled with depression. The resident reported he had experienced or witnessed a traumatic event in his life. Please note, per the assessment, the event was described as childhood trauma. The assessment asked if the care plan reflected the resident's needs and wishes related to trauma. The assessment was marked no. Additionally, the assessment indicated the resident had no cognitive impairment and planned to discharge back to the community. Review of ViaQuest Therapeutic Behavior Service (TBS) note, authored by TBS #575 dated 11/14/25, revealed the resident reported he had been to the dining room recently to eat but had not been to a group activity recently. Resident #22 stated my anxiety had been creeping in and I don't know why. Resident #22 talked about his door being shut while he was sleeping and when he woke up, he panicked. The resident reported when he was a kid his mom used to lock him in a closet while her boyfriend beat her and that door being shut brought those memories back. The resident was asked to practice Star (a calming technique designed to help manage stress and anxiety. It involves visualizing a star shape while coordinating breathing patterns to promote relaxation) breathing in session as we discussed times that he could have used it. Review of Resident #22's quarterly Minimum Date Set (MDS) assessment dated [DATE] revealed the resident's cognition was intact. The assessment noted the resident had little interest or pleasure 7-11 days, feeling down, depressed, or hopeless, 12-14 days, feeling tired or having little energy 7-11 days, feeling bad about yourself or that you are a failure or have let yourself or your family down 2-6 (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	days, and had thoughts that he would be better off dead, or of hurting self in some way 2-6 days. The resident had no behavior. Diagnoses included debility, malnutrition, anxiety, depression, asthma, respiratory failure and medication included anti-depressants, hypnotics, and opioids. The previous MDS, dated [DATE] revealed the resident had no mood or behaviors. Following the completion of this MDS, no changes were noted to be made to the resident's plan of care to address the identified mood changes. Review of Resident #22's annual social history and discharge planning assessment, dated 12/11/25 and authored by Social Service Designee #502, revealed the resident had a previous pill addiction. The resident reported he felt social isolation often. The resident had a history of not taking showers. The resident was not currently taking psychotropic medications (please note, the resident was receiving psychotropic medications). The note also indicated the resident had no significant life events/trauma history (Please note, the resident had previously discussed his childhood and issues with PTSD). The resident planned to become a long-term resident. The resident's quality of life objectives included engaging in hobbies, socializing, and staying active. Review of Resident #22 current plan of care, as of 03/03/26 revealed no evidence the resident had a plan of care for PTSD or any potential PTSD triggers throughout his comprehensive care plan such as leaving the resident's door open.Review of Resident #22's medical record revealed no evidence of a comprehensive assessment for PTSD. Observation on 02/23/26 at 2:27 P.M. revealed Resident #22 had a signed taped to his door that indicated leaving the resident's door open. Multiple observations during the onsite survey revealed the sign remained on the resident's door. Interview on 03/02/26 at 7:05 A.M. with Resident #22 revealed the sign on the door to leave the door open was a result of past trauma. He stated he woke up once and the door was closed and he curled up and was crying and saying it was not my fault per the staff. The resident reported he had past trauma that he needed to talk with the therapist about. Interview on 03/02/26 at 7:10 A.M. with RN #546 revealed the sign on Resident #22's door to leave the door open was there because the resident didn't like confined spaces and got anxious and would like the door open. Interview on 03/02/26 at 7:12 A.M. with Certified Nursing Assistant (CNA) #561 revealed she didn't know why the resident had a sign not to close the door hanging on his door. Interview on 03/02/26 at 12:02 P.M. with the DON verified she was unaware of the TBS note that indicated the resident's history of trauma as a child. The DON shared the facility currently had no residents with the diagnosis of PTSD. (Please note, the resident had a diagnosis of PTSD from the hospital upon admission to the facility on [DATE] however this was not included as an admission diagnosis). Additionally, the DON shared she was unaware (until the week of 02/23/26) the resident wanted his door open because when he wakes up and the door is closed, he freaks out. The DON revealed she had not investigated the reason why having the door closed upset the resident and thought the sign reminding staff to keep his door open was hung the week prior. The DON confirmed the resident's care plan had not been updated regarding the resident's door being kept open. Interview on 03/0326 at 8:03 A.M., with SSD #502 confirmed on admission the discharge summary from the hospital indicated the resident had PTSD and there was a treatment plan recommended. The SSD confirmed his admission assessment of Resident #22 indicated the resident had childhood trauma; however, a care plan was not initiated for PTSD and when he did his yearly assessment, he indicated the resident had no trauma. The SSD stated he documented what the resident reported even if there were discrepancies. Review of the facility assessment dated [DATE] revealed the facility collaborates with a variety of local community agencies to support residents with complex clinical and psychosocial needs. Through these partnerships, the facility ensures that clinical staff receive the guidance, education, and resources necessary to safely and effectively manage higher-acuity cases. These collaborative relationships strengthen the facility's ability to deliver comprehensive, person-centered care. We have a new admission program called MAP ([NAME] admission Partners) where we monitor the cases we are less familiar with.The facility manages medical conditions and medication-related issues that may contribute to psychiatric symptoms or behavioral expressions. Staff identify and implement individualized interventions to support residents (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	experiencing anxiety, cognitive impairment, depression, trauma-related conditions such as PTSD, other psychiatric diagnoses, and intellectual or developmental disabilities. The team utilizes ongoing assessment and monitoring to guide care approaches, including efforts to complete weekly PHQ-9 screenings when clinically appropriate. These practices help ensure timely identification of changes in mood, behavior, or mental health needs and support a person-centered plan of care.

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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 medical record review, interview, and policy review the facility failed to ensure residents were reviewed monthly by the pharmacist. This affected three (Resident #2, #3, and #22) of five reviewed for unnecessary medication review. Findings include: 1. Record review revealed Resident #22 was admitted to the facility on [DATE] with diagnosis including anxiety, need for assistance with personal care, insomnia, and depression. Review of Resident #22's medical record revealed no documented evidence the pharmacist completed a monthly medication regimen review for the month of October 2025. Interview on 03/02/26 at 9:26 AM with the Director of Nursing (DON) and Regional Director of Clinical Service #578 confirmed there was no documented evidence the pharmacist reviewed Resident #22 in October 2025. 2. Record review revealed Resident #2 was admitted to the facility on [DATE] with diagnosis including osteomyelitis, cellulitis, diabetes, depression, hypotension, renal dialysis, chronic ulcers, longer term use of anticoagulants, insulin, and aspirin, colon neoplasm, hyperlipidemia, anemia, Vitamin D deficiency, hypertension, heart disease, atrial fibrillation, gout, irritable bowel syndrome, exocrine pancreatic insufficiency, and urinary incontinence. Review of Resident #2's medical record revealed no documented evidence the pharmacist had completely a monthly medication regimen review for the month of October 2025. Interview on 03/02/26 at 12:02 P.M. with the DON revealed the pharmacist that completed the October 2025 had emailed her a blank list of residents whom he reviewed with no recommendations. The DON reported she had followed up a few days later and the pharmacist was supposed to send an updated list, however he never sent a list and she didn't follow back up with the pharmacist. Interview on 03/03/26 at 10:23 A.M., with Regional Director of Clinical Service #578 confirmed the facility had no documented evidence of residents who had medication regimen reviews in October 2025 that didn't require a recommendation. The pharmacist that completed the reviews in October was no longer employed by the pharmacy. He had spoken to the pharmacy, and they were going to complete an audit and reported the pharmacist had spent 10 hours in the facility and reported to his supervising pharmacist that he had completed a review, however there was no documentation to support which residents medication regimen he had reviewed. 3. Review of Resident #3's medical record revealed an admission date of 03/11/18 with diagnoses including acute and chronic respiratory failure with hypoxia and hypercapnia, chronic obstructive pulmonary disease with acute exacerbation, asthma, paranoid schizophrenia, unspecified psychosis, bipolar disorder, extrapyramidal and movement disorder, diabetes, dementia, and hypertension. Further review of Resident #3's medical record revealed no documentation that a pharmacy record review was completed for the resident in October 2025. In an interview on 03/03/26 at 10:15 A.M. Regional Director of Clinical Services (RDCS) #578 verified the pharmacy was unable to provide the facility with evidence that record reviews were completed for (continued on next page)

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	03/09/2026

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents who did not have recommendations for the facility or physician, to follow up on, for the month of October 2025. Review of the facility's policy and procedure titled Medication Regimen Reviews dated 2001 revealed a medication review regimen would be done upon admission and at least monthly thereafter. The goal of medication regimen review was to promote positive outcomes while minimizing adverse consequences and potential risk associated with medication.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews and policy review, the facility failed to ensure residents were provided with dental services to meet their needs. This affected two of five residents reviewed for dental (Residents #2 and #16). The facility census was 38.Findings include: 1. Medical record review for Resident #2 revealed the resident was admitted to the facility 04/28/25 on with diagnosis of diabetes, gastric-esophageal reflux disease, moderate protein calorie malnutrition, anemia, aphasia, and heart disease. Review of Resident #2's dental care plan related to loose fitting dentures dated 10/03/25 revealed to inform dentist of problems. Review of Resident #2's dental note date 10/17/25 revealed dental impression was obtained for new dentures. Further review of Resident #2's medical record revealed no evidence the resident had received new dentures or seen the dentist after 10/17/25. Review of Resident #2's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had broken or loose fitting full or partial dentures. Interview with Resident #2 on 02/23/26 at 10:40 A.M., revealed she had impression taken six or eight weeks ago for new dentures and had never heard anything else back. Interview on 03/03/26 at 1:08 P.M. with Social Service Designee #502 and Regional Director of Clinical Services #578 confirmed Resident #2 was seen by the in-house dentist on 10/17/25 and had impressions obtained for new dentures. The facility had cancelled their contract with the in-house dentist on 12/22/25. The new dentists visited on 02/04/26 however the resident was not seen. The Social Service Designee reported he called the previous dental service on 03/03/26 and they reported the dentures were not processed due to the facility cancelling services. The facility offered the resident to see an outside dentist on 03/03/26 and her appointment is on 03/17/26. The Social Service Designee confirmed the facility did not have an effective process for monitoring ancillary services to ensure services and treatments were not delayed and followed up with timely. 2. Review of the medical record for Resident #16 revealed an admission date of 12/16/19 and diagnoses including hepatic failure, alcoholic cirrhosis, diabetes, and chronic obstructive pulmonary disease. Review of the plan of care dated 02/07/24 revealed Resident #16 had oral/dental problems related to carious teeth. Natural teeth-multiple missing. Upper gumline has multiple teeth decayed to gumline and with functioning teeth. Lower gumline has one chipped tooth. Interventions included referral to a dentist. A Minimum Data Set (MDS) assessment completed 12/16/25 documented a brief interview for mental status score of 15 (intact cognition). An annual MDS assessment completed 09/15/25 indicated the resident had obvious or likely cavity or broken natural teeth. Interview with Resident #16 on 02/23/26 at 10:19 A.M. revealed she had broken and missing teeth. She stated they won't give her dentures because of her liver issues. A follow-up interview with Resident #16 on 02/26/26 at 8:15 A.M. revealed she would like to see the dentist due to the condition of her teeth. She was observed, at that time, with dark, carious teeth. Review of dental consults revealed she had not been seen by the dentist since 06/26/24. On 06/24/24 she refused to see the dentist. There was no evidence of any further attempts for a dental consult. Interview with Social Services #502 on 03/02/26 at 9:20 A.M. confirmed there was no evidence Resident #16 had been seen by a dentist since 06/26/24. He stated a new company began providing dental services for the facility in mid January 2026. He stated he just found out that he was the staff member who was supposed to have residents sign consents for dental (continued on next page)

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	365780	A. Building B. Wing	03/09/2026

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	services. He had not had Resident #16 sign a dental consent. He stated he did not know what having liver issues had to do with not receiving dental services as stated by the resident. Review of the facility's policy and procedure titled Dental Consultant dated 2001 revealed dental care shall be provided through the services of a consultant dentist. The consultant dentist is retained by the facility and is responsible for providing services related to dental matters. 1.Review of the record for Resident #16 revealed an admission date of 12/16/19 and diagnoses including hepatic failure, alcoholic cirrhosis, diabetes, and chronic obstructive pulmonary disease. A Minimum Data Set (MDS) assessment completed 12/16/25 documented a brief interview for mental status score of 15 (intact cognition). An annual MDS assessment completed 09/15/25 indicated the resident had obvious or likely cavity or broken natural teeth. Review of the plan of care dated 02/07/24 revealed Resident #16 had oral/dental problems related to carious teeth. Natural teeth-multiple missing. Upper gumline has multiple teeth decayed to gumline and with functioning teeth. Lower gumline has one chipped tooth. Interventions included referral to a dentist. Interview with Resident #16 on 02/23/26 at 10:19 A.M. revealed she has broken and missing teeth. She stated they won't give her dentures because of her liver issues. Interview with Resident #16 on 02/26/26 at 8:15 A.M. revealed she would like to see the dentist due to the condition of her teeth. She was observed, at that time, with dark, carious looking teeth. Review of dental consults revealed she had not been seen by the dentist since 06/26/24. On 06/24/24 she refused to see the dentist. There was no evidence of any further attempts for a dental consult. Interview with Social Services #502 on 03/02/26 at 9:20 A.M. confirmed there was no evidence Resident #16 had been seen by a dentist since 06/26/24. He stated a new company began providing dental services for the facility in mid January 2026. He stated he just found out that he is the one who is supposed to have residents sign consents for dental services. He has not had Resident #16 sign a dental consent. He stated he did not know what having liver issues had to do with not receiving dental services as stated by the resident.

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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 staff interview, the facility failed to ensure medical records were available for inspection. This affected two residents (#4 and #22) of 15 resident records reviewed. The facility census was 38.Findings Include: 1. Review of the record for Resident #4 revealed an admission date of 11/05/25 with diagnoses including malignant neoplasm of the lung, adult failure to thrive, acute kidney failure, and esophageal obstruction. The resident had a physician's order dated 11/10/25 for hospice services with diagnosis of malignant neoplasm of the lung. A notebook containing the hospice plan of care was noted at the nursing station. Review of the notebook indicated the resident would have visits from hospice staff including nurse, chaplain, and nursing assistant. However, there were no visit notes in the notebook since December 2025. Interview with Licensed Practical Nurse (LPN) #532 on 02/25/26 at 2:00 P.M. confirmed there were no hospice visit notes by nurses, aides, or chaplains since December 2025. She stated she had to call the hospice company to get the notes. Interview with the Director of Nursing on 02/26/26 at 8:10 A.M. confirmed the hospice visit notes were not routinely provided by the hospice agency for staff to review for care provided by the hospice staff. 2. Record review revealed Resident #22 was admitted to the facility on [DATE] with diagnosis of anxiety, insomnia, and depression. Review of the previous consulting Psychiatric Medical Doctor (MD) #888 behavioral note dated 09/05/25 revealed the resident had put on weight and was no longer able to effectively bathe himself but was resistant to getting bathed now. It noted that the resident remained unkempt and malodorous. It stated the resident would like to see a therapist, he was seeing someone from ViaQuest, but it was not believed they were therapists. The doctor noted the resident slept adequately, attending some activities, he was out of his room some, and there were no side effects to medications and the resident felt he was on a reasonable regimen. There was a recommendation to follow-up in 1.5 months. Review of Resident #22's medial record revealed no evidence of a follow-up visit. Interview on 03/02/26 at 12:02 P.M., with the Director of Nursing (DON) confirmed the resident was seen by MD #888 on 10/30/25 however the note was in her email and never printed and placed in the resident's medical record.