STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365784	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Square Healthcare Center	202 Washington Street NW Warren, OH 44483

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and review of facility policy, the facility failed to ensure all residents were treated with respect and dignity. This affected one resident (Resident #68) out of 11 residents reviewed for resident rights. The facility census was 67.Findings include:Review of Resident #68's medical record revealed an admission date of 12/12/25. Diagnoses included hyperlipidemia, difficulty in walking, repeated falls, hypertension, type two diabetes, anxiety, depression and chronic kidney disease.Review of Resident #68's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition, was able to make all needs know and required supervision with eating, assistance from staff with dressing, toileting, and self-propelled in his wheelchair.Interview on 03/24/26 at 11:30 A.M. with Resident #68 revealed on 03/20/26 at 9:30 A.M. he spoke with Certified Nursing Assistant (CNA) #819 and asked for his bed to be made and straighten up his room because his family was coming in for a visit. Resident #68 stated CNA #819 stated she would make it right away. Resident #68 stated at 1:30 P.M. his bed was still not made and approached CNA #819 while at the nurse's station and CNA #819 stated to him I'll get to it when I can very loudly and sternly and then walked away from the resident and never made his bed or cleaned up his room. Resident #68 stated he felt very disrespected and was visibly upset with how he was treated by CNA #819. Resident #68 stated Licensed Practical Nurse (LPN) #804 was at the nurse's station and witnessed CNA #819 tell him, I'll get to it when I can and then walk away. When asked if he reported this incident to anyone Resident #68 stated he did not due to feeling intimidated by the Administrator and knew state surveyors were in the building and wanted to report it to them. Resident #68 stated he felt the Administrator would not take his concerns seriously and would not do anything about them based on things he had reported in the past and how those things were handled.Interview on 03/24/26 at 1:11 P.M. with LPN #804 verified she was at the nurse's station when Resident #68 approached CNA #819 regarding not making his bed and witnessed her stated I'll get to it when I can loudly and sternly and then walk away from the resident and did not address this resident's needs.Review of the facility policy titled Resident Rights, dated 02/2021, revealed employees shall treat all residents with kindness, dignity and respect.This deficiency represents noncompliance investigated under Complaint Numbers 2708555 and 2721344.

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: 365784	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2026
NAME OF PROVIDER OR SUPPLIER Washington Square Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 202 Washington Street NW Warren, OH 44483	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and review of facility policy the facility failed to ensure residents were free from misappropriation of narcotics. This affected three residents (Residents #38, #41 and #69) of four residents reviewed for misappropriation of narcotics. The facility census was 67.Findings include:1.Review of the medical record for Resident #38 revealed an admission date of 09/29/23 with diagnoses including gangrene, hyperlipidemia, hypertension, peripheral vascular disease (PVD), cellulitis, type two diabetes, acquired absence of left toes, and muscle weakness.Review of Resident #38's care plan, revised 07/22/25, revealed the resident had actual pain related to cellulitis in left lower extremity. Staff were to monitor and document for side effects of pain medication, observe for constipation, new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria, nausea, vomiting, dizziness and falls, report all occurrences to the physician. Additionally, staff were to monitor, record, and report any signs and symptoms of non-verbal pain, changes in breathing, vocalizations, mood or behavior changes.Review of Resident #38's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition, was independent with eating and required supervision for all other Activities of Daily Living (ADLs).Review of Resident #38's physician orders dated March 2026 revealed an order for Oxycodone-Acetaminophen (narcotic pain medication) 10-325 milligram (mg) give one tablet by mouth every six hours as needed for pain.Review of Resident #38's Medication Administration Record (MAR) dated March 2026 revealed on 03/06/26 Resident #38 received one dose as ordered of Oxycodone-Acetaminophen 10-325 mg.Review of Resident #38's Narcotic sign out sheet revealed on 03/06/26 Licensed Practical Nurse (LPN) #816 signed out two doses of Oxycodone-Acetaminophen 10-325 mg both on 03/06/26 at 4:36 A.M.Interview on 03/12/26 at 1:07 P.M. with the Director of Nursing (DON) confirmed LPN #816 signed out two doses of Oxycodone-Acetaminophen on 03/06/26 at 4:36 A.M. for Resident #38 when only one dose was administered to the resident, and LPN #816 was suspended pending investigation for narcotic diversion. A follow-up interview on 03/24/26 at 3:07 P.M. with the DON revealed LPN #816 was sent for drug testing 10 days after being suspended for alleged narcotic diversion and tested negative, however, LPN #816 was ultimately terminated from the facility due to the misappropriation of narcotics related to Resident #38.2.Review of the medical record for Resident #41 revealed an admission date of 03/07/23. Diagnoses included Chronic Obstructive Pulmonary Disease (COPD), kidney stones, chronic kidney disease (CKD) stage three, viral hepatitis C, hypothyroidism, morbid obesity, mood disorder, bipolar disease, and anxiety.Review of Resident #41's annual MDS assessment dated [DATE] revealed the resident had intact cognition, was independent with eating and required partial to moderate assistance with all other Activities of Daily Living (ADLs).Review of Resident #41's physician orders dated March 2026 revealed an order for Hydrocodone-Acetaminophen (narcotic pain medication) 10-325 mg one tablet every morning and at bedtime for moderate to severe pain and give one tablet every 12 hours as needed for breakthrough pain.Review of Resident #41's Narcotic sign out sheets for Hydrocodone-Acetaminophen 10-325 mg dated November 2025, December 2025, January 2026, February 2026 and March 2026 revealed LPN #816 repeatedly signed out additional doses of this narcotic and not according to the physician orders as follows: On 11/16/25 at 8:00 P.M. one tablet was signed out and then again at 11:30 P.M. another tablet was signed out of Hydrocodone-Acetaminophen, less than six hours apart. On 11/17/25 at 7:30 P.M. one tablet was signed out and then again at 11:00 P.M. one tablet was signed out of Hydrocodone-Acetaminophen, less than six hours apart. On 11/23/25 one tablet was signed out at 2:00 A.M. and then again at 6:00 A.M. one tablet was signed out of Hydrocodone-Acetaminophen, less than six hours apart. On 11/24/25 one tablet was signed out at 8:00 P.M. and then again on 11/25/25 one tablet was signed out at 12:00 A.M. of Hydrocodone-Acetaminophen, less than six hours apart. On 11/27/25 one tablet was signed out at 8:00 P.M. and then again on 11/28/25 one tablet was signed out at 12:05 A.M. and (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Washington Square Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 202 Washington Street NW Warren, OH 44483	

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	then again on 11/28/25 on tablet was signed out at 5:02 A.M. of Hydrocodone-Acetaminophen, less than six hours apart. On 11/30/25 two tablets were signed out at 8:25 P.M. of Hydrocodone-Acetaminophen On 12/01/25 at 10:09 P.M. two tablets were signed out of Hydrocodone-Acetaminophen. On 12/06/25 one tablet was signed out at 8:00 P.M. then again one tablet was signed out at 11:34 P.M. Hydrocodone-Acetaminophen, less than six hours apart. On 12/08/25 one tablet was signed out at 7:45 P.M. then again one tablet was signed out at 11:30 P.M. with another additional tablet signed out on 12/09/25 at 4:21 A.M. Hydrocodone-Acetaminophen, less than six hours apart. On 12/14/25 one tablet was signed out at 7:15 P.M. then another tablet again on 12/15/25 at 12:06 A.M. and another tablet signed out again at 4:23 A.M. Hydrocodone-Acetaminophen, all less than six hours apart. On 12/15/25 one tablet was signed out at 7:39 P.M. then one tablet signed out again on 12/16/25 at 12:00 A.M. and one tablet signed out again on 12/16/25 at 4:51 A.M. of Hydrocodone-Acetaminophen, all less than six hours apart. On 12/20/25 one tablet was signed out at 8:00 P.M. then another tablet again on 12/21/25 at 1:40 A.M. and another tablet again on 12/21/25 at 6:00 A.M. of Hydrocodone-Acetaminophen, all less than six hours apart. ON 12/21/25 one tablet was signed out at 1:40 A.M. then again at 6:00 A.M. of Hydrocodone-Acetaminophen, less than six hours apart. On 12/22/25 one tablet was signed out at 7:15 P.M. then again one tablet at 11:45 P.M. of Hydrocodone-Acetaminophen, less than six hours apart. On 12/24/25 one tablet signed out at 7:30 P.M. then one tablet signed out again at 11:50 P.M. and one tablet signed out again on 12/25/25 at 4:44 A.M. of Hydrocodone-Acetaminophen, less than six hours apart. On 12/26/25 one tablet signed out at 7:30 P.M. then one tablet signed out again at 11:45 P.M. of Hydrocodone-Acetaminophen less than six hours apart. On 12/29/25 at 7:30 P.M. then again at 11:37 P.M. one tablet of Hydrocodone-Acetaminophen was signed out less than six hours apart. On 01/02/26 at 8:00 P.M. then on 01/03/26 at 12:00 A.M. then again at 5:00 A.M. one tablet each time of Hydrocodone-Acetaminophen was signed out less than six hours apart. On 01/05/26 at 7:30 P.M. then again at 11:13 P.M. Hydrocodone-Acetaminophen one tablet each time was signed out less than six hours apart. On 01/08/26 at 7:15 P.M. then again at 11:23 P.M. Hydrocodone-Acetaminophen one tablet each time was signed out less than six hours apart. On 01/11/26 at 7:30 P.M. then again on 01/12/26 at 12:03 A.M. Hydrocodone-Acetaminophen one tablet each time was signed out less than six hours apart. On 01/13/26 at 7:30 P.M. then again at 11:40 P.M. Hydrocodone-Acetaminophen one tablet each time was signed out less than six hours apart. On 01/16/26 at 7:45 P.M. then again at 11:13 P.M. Hydrocodone-Acetaminophen one tablet each time was signed out less than six hours apart. On 01/17/26 at 7:52 P.M. then again on 01/18/26 at 12:00 A.M. Hydrocodone-Acetaminophen one tablet each time was signed out less than six hours apart. On 11/22/26 at 8:00 P.M. then again at 11:28 P.M. Hydrocodone-Acetaminophen one tablet each time was signed out less than six hours apart. On 01/30/26 at 800 P.M. then again on 01/31/26 at 12:00 A.M. Hydrocodone-Acetaminophen one tablet each time was signed out less than six hours apart. On 01/31/26 at 7:32 P.M. and then on 02/01/26 at 12:06 A.M. Hydrocodone-Acetaminophen one tablet each time was signed out less than six hours apart. On 02/05/26 at 7:30 P.M. then on 02/06/26 at 1:15 A.M. then again at 6:00 A.M. Hydrocodone-Acetaminophen one tablet each time was signed out less than six hours apart. On 02/13/26 at 9:00 P.M. then on 02/14/26 at 1:30 A.M. then again at 6:15 A.M. Hydrocodone-Acetaminophen one tablet each time was signed out less than six hours apart. On 02/14/26 at 8:03 P.M. then again at 11:49 P.M. Hydrocodone-Acetaminophen one tablet each time was signed out less than six hours apart. On 02/16/26 at 7:45 P.M. then again on 02/17/26 at 12:17 A.M. Hydrocodone-Acetaminophen one tablet each time was signed out less than six hours apart. On 02/19/26 at 2:00 A.M. then again at 6:15 A.M. Hydrocodone-Acetaminophen one tablet each time was signed out less than six hours apart. On 02/19/26 at 9:26 P.M. then on 02/20/26 at 1:00 A.M. Hydrocodone-Acetaminophen one tablet each time was signed out less than six hours apart. On 02/27/26 at 7:30 P.M. then again at 11:42 P.M. Hydrocodone-Acetaminophen one tablet each time was signed out less than six hours apart. On 02/28/26 at 8:00 P.M. then again on 03/01/26 at 12:05 A.M. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365784	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Square Healthcare Center	202 Washington Street NW Warren, OH 44483

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hydrocodone-Acetaminophen one tablet each time was signed out less than six hours apart. On 03/05/26 at 7:45 P.M. and again on 03/06/26 at 12:01 A.M. Hydrocodone-Acetaminophen one tablet each time was signed out less than six hours apart. All the additional doses were given only by LPN #816.A confidential interview on 03/10/26 at 4:43 P.M. revealed concerns with medication administration of narcotics by LPN #816 for Resident #41 consisting of when LPN #816 worked she would sign out extra doses of Resident #41's Hydrocodone-Acetaminophen 10-325 mg and the way LPN #816 was signing the medication out was not by physician orders and at times multiple doses of the medication were signed out on the same time and date. Resident #41 was only to have one pill at a time and was scheduled to have the medication every 12 hours and did not ask for additional doses of this pain medication. These concerns were brought to the DON since November 2025 multiple times who had done nothing about it. An interview on 03/12/26 at 9:54 A.M. with the Director of Nursing (DON) revealed she had concerns related to misappropriation brought to her by the Ombudsman based off resident interviews. One of the residents involved was Resident #41. She stated when LPN #816 worked there was consistently additional doses signed out of narcotic pain medication and confirmed it was the Hydrocodone-Acetaminophen. The DON stated a self-reported incident was filed with the Ohio Department of Health and the intervention put in place was to have two nurses sign off on the narcotic sign off sheet when Resident #41 received pain medication. The DON stated on review of Resident #41's narcotic sign-off sheets she seen what we seen regarding LPN #816 being the only nurse signing out additional doses of Hydrocodone-Acetaminophen for Resident #41. The DON verified the findings of Resident #41's narcotic sign-off sheets. An interview on 03/12/26 at 11:09 A.M. with Resident #41 revealed she was alert, oriented to person, place, time and situation, and able to answer both simple and complex questions. Resident #41 stated she received pain medication every 12 hours, it controlled her pain and she did not ask for any additional doses of her pain medication because she knew she was scheduled to receive it every 12 hours. She stated she became aware of a concern that extra doses of her pain medication were being signed out, and she had discussed these concerns with the Ombudsman. Resident #41 stated she did not receive nor ask for these extra doses. 3.Review of Resident #69's medical record revealed and admission date of 10/21/25 and a discharge date of 11/25/25. Diagnoses included Peripheral Vascular Disease (PV), COPD, chronic kidney disease, heart failure, type two diabetes, hypertension, gout, and cerebrovascular disease.Review of Resident #69's discharge MDS dated [DATE] revealed the resident had intact cognition and was independent with ADLs.Review of Resident #69's physician orders dated November 2025 revealed the resident was prescribed Oxycodone-Acetaminophen (narcotic pain medication) 5-325 mg every six hours as needed for moderate to severe pain.Review of Resident #69's narcotic sign-off sheet revealed after the resident had discharged from the facility on 11/25/25 LPN #810 signed out a dose of medication on 11/27/25, and LPN #816 signed out two doses of medication on 11/28/25 and one dose on 11/29/25. The narcotic sign-off sheet was signed that medications were wasted however this was unable to be verified by the facility administration during the survey. LPN #810 and LPN #816 documented they witnessed each other's wasted medications. A confidential interview on 03/10/26 at 4:43 P.M. revealed concerns with medication administration of narcotics by LPN #816 involving Resident #69 that included LPN #816 signing out multiple doses of narcotic pain medication days after Resident #69 discharged from the facility in November 2025. Interview on 03/12/26 at 1:07 P.M. with the DON revealed for Resident #69 the nurses documented correctly that the medications were wasted. The DON verified the findings on the narcotic sign-off sheet for Resident #69 and stated she had no explanation why LPN #816 and LPN #810 were pulling narcotics for Resident #69 days after his discharge 11/25/25. The DON stated she could not verify if the medications were wasted. Interview on 03/24/26 at 3:07 P.M. with the DON revealed LPN #810 had her employment terminated at the facility on 02/25/26 for working at the facility with a suspended nursing license as of 01/22/26 due to narcotic diversion. Review of the undated facility policy titled Controlled Substance Administration and Accountability revealed it was the policy of the facility to promote safe, high quality patient care, (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Washington Square Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 202 Washington Street NW Warren, OH 44483	

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility was to have safeguards in place to prevent loss, diversion or accidental exposure.Review of the facility policy titled Resident Rights to Freedom from Abuse, Neglect, and Exploitation, undated, revealed the facility residents have a right to be free from abuse and misappropriation of their property. The facility will take all appropriate steps to remediate noncompliance within appropriate timeframes according to federal and state regulations, conduct a thorough investigation, take appropriate corrective action, and will not employ individuals that have disciplinary action against their professional license. This deficiency represents non-compliance investigated under Complaint Number 2801908.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365784	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2026
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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of the facility self-reported incident (SRI) and investigation, and policy review the facility failed to ensure allegations of misappropriation of narcotics were thoroughly investigated. This affected three residents (Residents #28, 41 and #69) out of four residents reviewed for misappropriation of narcotics. The facility census was 67.Findings include:Review of SRI 271810 reported to the Ohio Department of Health (ODH) on 03/06/26 at 7:40 P.M. by the facility Administrator revealed an allegation of misappropriation was being reported. The alleged perpetrator was Licensed Practical Nurse (LPN) #816 and three residents (#28, #41 and #69) were allegedly involved. A brief description included that residents reported increased pain requiring additional medication and an investigation was initiated to ensure medications were being given. The facility unsubstantiated that abuse/misappropriation had occurred based on inconclusive evidence that misappropriation had occurred. There was no mention in this SRI report that Resident #69 was a discharged resident and that narcotics had been signed out as wasted by LPN #816 after his discharge from the facility. Review of the facility investigation revealed the following evidence of lack of a thorough investigation: Review of the interviews conducted with nursing staff revealed the interviews were not dated and asked only two questions: Have you been educated on the abuse, neglect and misappropriation policy, and do you know who to report misappropriation and narcotic diversion to? Ten of 14 interviews were signed only by the Director of Nursing (DON) as completed verbally/over the phone. There was no interview from LPN #806 who was employed at the facility during the survey. Review of the MAR to Cart Audit Narcotic Reconciliation audit sheets revealed no information on the sheets of who completed it, dates of completion were missing on some of the sheets and whether the counts were correct was not filled out on 03/12/26 for the [NAME] Unit Cart two for one resident audited. There were no written statements in the investigation from Resident #28 or Resident #41 or their responsible party and other resident interviews revealed the questions were limited to asking if they received their pain medications and did they know who to report to if they did not? There was no evidence LPN #816 was specifically questioned about Resident #69's narcotic sign-out sheets indicating LPN #816 had signed out narcotics and marked the narcotics as wasted after Resident #69 had discharged from the facility on 11/25/25. The alleged perpetrator LPN #816 was not sent for drug testing until 10 days after the SRI was initiated on 03/06/26. An interview on 03/24/25 at 2:45 P.M. with the Director of Nursing (DON) revealed she was unsure how to complete a thorough investigation as there was no written policy on how to investigate facility SRIs. The DON stated the Administrator was the Abuse Coordinator, but she was directly involved with the misappropriation investigation for narcotic diversion, and several other staff were involved with the SRI. The DON verified LPN #816 was not sent for drug testing until 10 days after the SRI was initiated, verified staff interviews were undated, limited in scope of questions and were not filled out by all nursing staff, and verified no written witness statements from the involved residents or their responsible parties. The DON also verified no evidence LPN #816 was questioned about signing out narcotics for Resident #69 after discharge and stated she could not prove the narcotics were wasted with the SRI investigation that was conducted. Review of the facility policy titled Resident Rights to Freedom from Abuse, Neglect, and Exploitation, undated, revealed the facility residents have a right to be free from abuse and misappropriation of their property. The facility will take all appropriate steps to remediate noncompliance within appropriate timeframes according to federal and state regulations, conduct a thorough investigation, and take appropriate corrective action. This deficiency represents noncompliance investigated under Complaint Number 2801908.

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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 record review, review of care conference meeting documents, resident and staff interview, and review of facility policy, the facility failed to ensure all minimum required members of the Interdisciplinary team were present during care plan meetings. This affected one resident (Resident #41) out of 11 residents reviewed for care plans. The facility census was 67.Findings include:Review of Resident #41's medical record revealed an admission date of 03/07/23. Diagnoses included Chronic Obstructive Pulmonary Disease (COPD), kidney stones, chronic kidney disease (CKD) stage three, viral hepatitis C, hypothyroidism, morbid obesity, mood disorder, bipolar disease, and anxiety.Review of Resident #41's annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition was independent with eating and required partial to moderate assistance with all other Activities of Daily Living (ADLs).Review of Resident #41's Care Conference meeting notes dated 03/03/26 revealed the only attendees were Resident #41, Resident #41's Power of Attorney (POA), and Social Service Designee (SSD #812). There was another signature for an MDS nurse, however, it could not be verified this person attended the meeting by the content of the notes. There were no other representatives present from the Interdisciplinary team.Interview on 03/12/26 at 12:30 P.M. with Resident #41 revealed she verified her care conferences were held in her room and the only attendees were the resident, the resident's representative/POA, and SSD #812. Resident #41 stated they do not review the medications at these meetings and they only last approximately 10 minutes. Resident #41 stated she is told to sign a paper at the end of the meeting, signs a paper at the end of the meeting but does not know what it is she is signing.Interview on 03/25/26 at 1:15 P.M. with Resident #41's POA revealed the only attendees for the care conferences were the resident, herself and SSD #812. She stated Resident #41's medications are not reviewed during the meeting.Interview on 03/25/26 at 3:00 P.M. with SSD #812 verified during care conference meetings it is only herself, the resident and the resident's representative if they chose to come in or via phone. SSD #812 stated if the resident should bring up concerns related to other areas such as therapy, dietary, nursing, or activities she will send them in after the meeting to address the resident's concerns, as they do not take part during the actual meeting.Review of the undated facility policy titled Comprehensive Care Plan revealed it did not address the minimum required members of the interdisciplinary team who are required to be present at care conference meetings.This deficiency is an incidental finding identified during investigation of Complaint Number 2801908.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of personnel files and review of the facility corrective action, the facility failed to ensure that all nursing staff were competent and legally licensed to provide nursing care and services to residents. This had the potential to affect all residents residing in the facility. The facility census was 67.Findings include:Review of the Ohio Board of Nursing (OBN) document Order, Suspension of License, revealed on 01/22/26 Licensed Practical Nurse (LPN) #810's professional license was suspended due to narcotic diversion.Review of LPN #810's employee file revealed a hire date of 02/25/25 and a termination date of 02/25/26. There was no evidence in the file of a quarterly licensure verification completed by the facility on LPN #810's license.A confidential interview on 03/10/26 at 4:43 P.M. revealed concerns regarding LPN #810's professional license being suspended due to issues with narcotics and concern that LPN #810 continued to work without a license as a nurse providing nursing care to residents at the facility.Interview on 03/11/26 at 2:39 P.M. with the Director of Nursing (DON) revealed LPN #810 had been working at the facility for approximately one month after her LPN license was suspended by the OBN. The DON stated she was informed by Human Resource Supervisor (HRS) #813 but could not recall when she found out. The DON stated LPN #810 was suspended immediately but was unsure if she had been terminated. When asked whose responsibility it was to check the nurses' professional licenses, the DON stated she believed it was HRS #813's job. The DON verified LPN #810 worked full-time on nightshift from 6:30 P.M. to 7:00 A.M. and worked on both the [NAME] and [NAME] units. The DON verified LPN #810 worked 13 shifts with a suspended license at the facility and completed all nursing duties which included passing medications to residents.Interview on 03/11/26 at 3:34 P.M. with the Administrator and the HRS #813 revealed the Administrator received an anonymous phone call on 02/25/26 stating LPN #810 was working with a suspended license. The Administrator immediately informed HRS #813 and an investigation was started with the suspension/termination of LPN #810. The Administrator stated through the investigative process it was discovered nursing licenses were to be checked and verified as active on hire, quarterly and annually. The Administrator stated this was not being completed. When asked whose responsibility this was, he stated it was the DONs and HR Supervisors responsibility.Review of the facility binder of corrective action, date initiated 02/25/26, revealed the facility implemented corrective action due to LPN #810 working in the facility with a suspended license which had the potential to affect all residents. The medical director and OBN were notified. All residents were assessed, narcotic reconciliation was done on all medication carts, psychosocial assessments were done on all residents and licensure verification was done for all nurses. Staff education was completed on 02/25/26 and length of education was 15 minutes on the facility hiring process/procedure including verification of licensure for nurses upon hire, quarterly and annually by the Administrator/designee to the Human Resources Manager. The Administrator/designee educated all staff on the facility misappropriation policy. The DON/designee educated all nurses on OBN licensure requirements for nurses and the facility policy/procedure for licensure verification and narcotic reconciliation policy. However, upon review of the sign-in attendance documentation records revealed incomplete evidence of staff signatures that included only 20 staff signatures of 84 staff listed on the records for education on Misappropriation and/or Licensure Requirements. The teaching method was listed as verbal explanation, on-line text learning or via phone. For the records of education of OBN Licensure Requirements and Narcotic Reconciliation presented by the DON/designee on 02/25/26, the records revealed incomplete evidence of staff signatures that included only five nurse signatures of 16 nurses listed on the records for education. The teaching method was explanation. The nurses who did not provide a signature were educated verbally on 02/25/26. There was no evidence of post-education competency testing.Further review of the (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Square Healthcare Center	202 Washington Street NW Warren, OH 44483

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	corrective Controlled Substance Reconciliation QI Tool documents revealed audits began on 02/26/26 for narcotic medications administered timely and documented correctly, and delivery reconciled and documented. There was no evidence of a look back period being assessed for discrepancies in administration of narcotics.Interview on 03/24/26 at 3:07 P.M. with the DON confirmed the contents of the corrective actions and stated most of the staff education was completed verbally by phone or through a text messaging system and staff signatures were not obtained. The DON stated the text messaging system did not provide receipt that staff acknowledged looking at the message, she thought there was a way to see who looked at the message, but could not provide any evidence. The DON verified additional audits had not been completed to look for discrepancies in narcotic administration other than what was in the corrective action binder. This deficiency represents noncompliance investigated under Complaint Number 2801908.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to ensure residents were free of significant medication errors. This affected one resident (Resident #70) of 11 residents reviewed for medication administration. The facility census was 67.Findings include:Review of Resident #70's medical record revealed an admission date of 08/13/25 and a discharge date of 11/20/25. Diagnoses included chronic kidney disease stage four, depression, cerebral infarction, osteoarthritis, lower back pain, Alzheimer's disease, Post Traumatic Stress Disorder (PTSD), pressure ulcer of left heel stage three, and pneumonitis due to inhalation of food and vomit.Review of Resident #70's discharge Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had cognitive impairment and was dependent on staff for all Activities of Daily Living (ADLs) including medication administration.Review of Resident #70's physician orders dated November 2025 revealed the resident was to receive Fentanyl Transdermal Patch 72-hour 25 microgram (mcg) per hour, apply one patch transdermal one time a day every three days for chronic pain, place patch on upper arm, chest or upper back. Change every 72 hours, rotate sites.Review of Resident #70's Medication Administration Record (MAR) dated November 2025 revealed the resident was to receive a new Fentanyl patch on 11/17/25 and did not.Review of Resident #70's Controlled Substance Administration Record for Fentanyl Patches revealed nursing staff applied a patch on 11/14/25 as ordered and was scheduled to have a new patch applied three days later, on 11/17/25 per physician orders and did not receive the new patch. Additionally, a new patch was not administered until 11/20/25.Interview on 03/12/26 at 1:07 P.M. with the Director of Nursing (DON) revealed she verified nursing staff did not administer Fentanyl patch to Resident #70 per physician orders.Review of the facility policy titled Administering Medications, last revised December 2012, revealed medications were to be administered in a safe and timely manner, and as prescribed.This deficiency represents noncompliance investigated under Complaint Number 2801908.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview the facility failed to demonstrate effective leadership of the overall facility operations to ensure each resident attained/maintained their highest practicable physical, mental, and psychosocial well-being. This affected five residents (#3, #28, #41, #43, and #68) and had the potential to affect all residents in the facility. The facility census was 67.Findings include:Review of the job description for the position of Administrator revealed it was signed by the facility Administrator on 09/13/24. The position summary included leading and directing the overall operation of the facility in accordance with resident needs, government regulations, and company policies to maintain quality of care for the residents while achieving the facility's business directives. Administrative duties included but were not limited to maintaining working knowledge and ensuring compliance with all governmental regulations, monitoring employee relations practices of key staff to ensure compliance with employment laws and company policies, promoting practices that maintain high morale and staff retention including effective communication, prompt problem resolution and positive reinforcement. Role responsibilities included interpersonal skills such as interacting with residents, family members, co-workers, ancillary staff in a non-judgmental, supportive calm manner. Addresses family satisfaction issues and assists in resolving the matter in a professional manner; Is aware of the Resident Abuse Reporting Law. Resident care responsibilities for resident dignity include ensures understanding of, and compliance with, all rules regarding resident rights, addresses residents in a respectful manner, and discuss confidential resident information in appropriate area only.Review of the job description for the position of Director of Nursing revealed it was signed by the DON on 10/02/25. The position summary included under the supervision of the administrator, has authority, responsibility, and accountability for functions, activities and training for the nursing services staff, in addition to the Therapy Department and its functions within the facility. In the absence of the Administrator, assumes responsibility for the facility. Is responsible for the overall management of resident care 24 hours a day, seven days a week. Conducts periodic reviews that the facility and personnel are in compliance with state code requirements. Meets with all licensed staff on a routine basis to review nursing and facility issues. Ensure plans are in place to correct employee concerns. Is aware of resident abuse reporting law. During the onsite investigation, the following concerns related to the Administrators' and DONs' role responsibilities were identified: a. An interview was conducted on 03/24/26 at 8:10 A.M. with the state Ombudsman who revealed the Director of Nursing (DON) was informed on 03/05/26 of a resident concern related to alleged staff misappropriation of resident medications which involved Resident #28 and #41. The Ombudsman stated the DON stated this is so out in left field when the Ombudsman told her who the licensed practical nurse (LPN #816) was that the residents suspected of misappropriation. The Ombudsman stated she had also brought the concerns to the Administrators attention about the alleged staff misappropriation of resident medications which involved Resident #28 and #41. The Administrator stated to the Ombudsman unless the police are called, I won't be doing anything about it, he stated it did not matter and stated I don't know what to say about it. The Ombudsman stated it was not until the Regional Director of Operations (RDO) was contacted by the Ombudsman's office that a Self-Reported Incident (SRI) investigation was opened (SRI 271810). (See findings under F602). An interview on 03/24/25 at 2:45 P.M. with the Director of Nursing (DON) revealed she was unsure how to complete a thorough investigation as there was no written policy on how to investigate incidents/SRIs. The DON stated the Administrator was the Abuse Coordinator and there were multiple staff members who helped with each SRI. The DON confirmed she was directly involved with narcotic misappropriation investigations including SRI 271810. (See findings under F610).Confidential interview with a staff member revealed they were aware the DON was informed of concerns with misappropriation of resident's narcotics and did not do anything about it and did not take concerns (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	seriously. There was no investigation started. The confidential interview also revealed staff felt when concerns were brought to the DONs attention nothing gets done and things are just ignored or brushed under the rug. When asked if staff and residents are interviewed for SRI investigations, the staff member stated that the questions asked to staff and residents are generic and vague, and the questions do not get to the real issue.An interview on 03/11/26 at 2:39 P.M. with the Director of Nursing (DON) revealed LPN #810 had been working at the facility for approximately one month after her LPN license was suspended related to narcotic diversion. The DON stated she was informed by Human Resource Supervisor (HRS) #813 but could not recall when she found out. The DON stated LPN #810 was suspended but was unsure if she had been terminated. When asked whose responsibility it was to check the nurses' professional licenses she stated she believed it was HRS #813's job. The DON verified LPN #810 worked full time on nightshift from 6:30 P.M. to 7:00 A.M. and worked on both the [NAME] and [NAME] units. The DON verified LPN #810 worked 13 shifts with a suspended license at the facility. (See Findings under F726).Interview on 03/11/26 at 3:34 P.M. with the Administrator and HRS #813 revealed the facility had a policy in place that nursing licenses were to be checked and verified as active on hire, quarterly and annually but this was not being completed until LPN #810 was terminated on 02/25/26. (See Findings under F726).b. An interview on 03/24/26 at 11:30 A.M. with Resident #68 revealed he did not feel he could bring his concerns to the Administrator because the Administrator was intimidating and would not take his concerns seriously nor do anything about them. A confidential interview with a staff member revealed when concerns were brought to the Administrator about incidents in the facility the staff member felt frightened to report to him because the Administrator raised his voice over what the staff member had reported to him in the past as if he did not want to hear it.c. Review of the Self-Reported Incident (SRI) 271526 filed with the Ohio Department of Health (ODH) on 02/28/26 at 9:24 A.M. revealed the facility reported an allegation of physical abuse between Resident #3 and Resident #43 that was unwitnessed. However, three staff (CNA #820, #940 and #941) were identified as staff Resident #43 reported to about the incident. The narrative summary of incident investigation indicated Resident #43 told these staff that Resident #3 placed his hands in the vicinity near Resident #43's neck. However, no one saw it. The residents were separated and found without injury. Both residents denied the incident occurred and stated they felt safe. Other staff and residents were interviewed and residents were interviewed. The facility unsubstantiated that abuse had occurred. The investigation was closed on 03/06/26. Review of the facility SRI investigation revealed there were no written witness statements by CNA #820, #941 and #940 in the file. There were three staff interviews from CNA #820, #940 and #941 which were typed out and signed only by the Administrator. An interview on 03/24/26 at approximately 12:00 P.M. with the Regional Director of Clinical Operations (RDCO) verified no written witness statements by staff were in the SRI investigation file. The RDCO stated she would go check with the Administrator.An interview on 03/24/25 at approximately 3:00 P.M. with the RDCO revealed the Administrator had dumped a box out onto the floor in his office and found the handwritten witness statements from CNA #820, #940 and #941. Review of the handwritten witness statements revealed the Administrator had omitted several details from CNA #820's written statement dated 02/28/26. CNA #820 wrote that Resident #43 told her Resident #3 yelled an expletive at him, threatened him, approached him with a tray table and he was scared. The typed staff interview version signed only by the Administrator stated Resident #3 told him to shut up and placed something over his neck. Interviews on 03/25/26 between 11:00 A.M. and 11:30 A.M. by the state surveyor with Resident #3 and #43 revealed both residents reported feeling safe in the facility and neither reported abuse. Neither resident could recall the incident from 02/28/26. An interview was conducted on 03/24/26 at 4:00 P.M. with the Administrator, RDCO, RDO and the Corporate Risk Nurse (CRN) to discuss the discrepancies in the content of SRI 271526 witness statements. Both versions were read aloud to the group by the surveyor. When asked to explain the discrepancies, the Administrator stated you can't understand what they write anyway because they write how they speak. The Administrator stated he (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	preferred to type out his own interviews to use as statements for the SRI investigations because he thought he was adding depth to what the employees were writing. The Administrator stated he was on vacation when the incident occurred and when asked when he was on vacation he stated I don't know. At the end of the interview the Administrator was observed walking out of the room down the hall and could be heard loudly and clearly stating you can't fix stupid from approximately 10 feet down the hall. It was observed that there was office doors open in this hallway with staff sitting in the offices. This deficiency is an incidental finding identified during investigation of Complaint Number 2801908, 270855 and 2721344.

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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, interviews, review of the facility self-reported incident, and review of facility policy, the facility failed to ensure complete and accurate medical records were maintained for Resident #3 and Resident #43. This affected two residents (Resident #3 and Resident #43) out of 11 residents reviewed for resident records. The facility census was 67.Findings include:Review of the facility self-reported incident dated 02/28/26 revealed staff reported an allegation of physical abuse between Resident #3 and Resident #43. Details included Resident #3 placing his hands in the vicinity near Resident #43's neck, however, it was not seen by staff or anyone. The residents were separated, assessed to be free from injury, placed on 15-minute checks, and a room change was implemented to further separate the residents. The facility unsubstantiated that abuse had occurred.Review of the medical record for Resident #3 revealed an admission date of 02/05/26 with diagnoses including schizoaffective disorder, anxiety, paranoid schizophrenia and hypothyroidism.Review of Resident #3's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had some cognitive impairment but was able to answer simple questions accurately and make needs known. Resident #3 was independent with most Activities of Daily Living (ADLs) except eating which required supervision. Resident #3 was dependent on nursing staff to provide medications.Review of Resident #3's care plan initiated on 02/23/26 with revisions on 03/05/26 revealed the resident had a behavior problem including agitation, yelling out, repeatedly placing trash cans from room into the hallway related to schizoaffective disorder and anxiety. Interventions included staff administering medications as ordered, monitoring and documentation of side effects and effectiveness, anticipating and meeting the resident's needs. Care givers were to provide opportunities for positive interactions, attention, and to stop and talk with him as they passed by. If reasonable, staff were to discuss the Resident's behavior, explain or reinforce why behavior was inappropriate and/or unacceptable. Staff were to intervene as necessary to protect the rights and safety of others. Finally, staff were to monitor behavior episodes and attempt to determine underlying causes. Consider location, time of day, people involved and situations. Document behaviors and potential causes.Review of Resident #3's progress notes dated 02/27/26 through 03/25/26 revealed there was no documentation addressing resident to resident altercation that occurred throughout the night on 02/27/26 to 02/28/26. There was no documentation regarding notification to Resident representative of altercation or room change that occurred. Additionally, there was no documentation of notification to the physician of resident-to-resident altercation.Review of the medical record for Resident #43 revealed an admission date of 12/07/25 with diagnoses including Post Traumatic Stress Disorder (PTSD), mild cognitive impairment, nontraumatic subdural hemorrhage, and major depressive disorder.Review of Resident #43's quarterly MDS assessment dated [DATE] revealed the resident had cognitive impairment and required assistance with ADLs including medication administration.Review of Resident #43's care plan initiated on 11/01/25 revealed there was no care plan related to the resident having behaviors.Review of Resident #43's progress notes dated 02/27/26 through 03/25/26 revealed there was no documentation addressing resident to resident altercation that occurred throughout the night on 02/27/26 to 02/28/26. There was no documentation regarding notification to Resident representative of altercation or room change that occurred. Additionally, there was no documentation of notification to the physician of resident-to-resident altercation.Review of the facility incident/accident log dated 02/01/26 to 03/25/26 revealed the resident-to-resident altercation that occurred between Resident #3 and Resident #43 on 02/28/26 was not listed on the report.Interview on 03/24/26 at 2:45 P.M. with the Director of Nursing (DON) and with the Regional Director of Clinical Operations #901 (RDCO) revealed they both verified there was no documentation in Resident #3's or Resident #43's medical record regarding the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident-to-Resident altercation that occurred between 02/27/26 and 02/28/26. They also confirmed there was no documentation indicating notification was made to the physician or the resident representatives.Review of the undated facility policy titled Resident's Right to Freedom from Abuse, Neglect, and Exploitation Policy and Procedure, revealed the facility shall review altercations from resident to resident as a potential situation of abuse including physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, and throwing objects. Additionally, the facility will ensure all allegations are investigated and documented thoroughly.This deficiency is an incidental finding identified during investigation of Complaint Number 2801908, 270855 and 2721344.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility records review and facility policy review, the facility failed to ensure the shower room on the [NAME] Unit was maintained in sanitary condition and good repair. This had the potential to affect all 37 (#1, #4, #7,#8, #9, #10, #12, #14, #17, #19, #21, #22, #25, #26, #27, #32, #34, #35, #38, #41, #42, #44, #46, #49, #50, #52, #53, #54, #56, #57, #58, #61, #62, #63, #64, #66, and #67) residents on the [NAME] Unit. The facility census was 67.Findings include:Observation on 03/10/26 at 1:30 P.M. of the [NAME] Unit shower room revealed the room was humid, and the ceiling vent did not turn on upon activation of the switch. The baseboard radiator was dented and rusty. Behind the toilet where the wall met the floor was a build-up of black substance for approximately 15 tiles, and each floor tile measured two inches by two inches. Upon entering the shower area, to the left above the shower head were approximately five to six black spots on the ceiling. At the bottom of the same wall where it met the floor tile for approximately five tiles was a built-up of black substance in the grout lines and on the wall. Two other walls also had black, discolored tiles along the floor line. The shower ceiling had an oval area approximately eight to nine inches with black substance spots. There was a pervasive mildewy, damp-smelling odor in this room. Interview on 03/10/20 at 1:40 P.M. with Regional Director of Operations #900, (RDO) confirmed the findings in the [NAME] Unit shower room. RDO #900 also stated he was unsure what department was responsible for keeping the shower room clean and maintained.Interview and observation on 03/10/26 at 2:25 P.M. with the Administrator and Maintenance Director (MD) #801 in the [NAME] Shower room revealed the air vent was not currently working, the shower room did not have adequate ventilation which was leading to a mildew issue, so the air vent would need to be repaired. MD #801 stated he can't fix things if he is not told they are broken.Review of the maintenance request notebook from January 2026 to current revealed on 01/07/26 a notation indicated [NAME] shower broke with notation: repair completed on 01/07 by DF.Interview with Housekeeper #807 on 03/11/26 at 8:30 A.M. revealed in addition to resident rooms, they are responsible to clean non-resident room areas which are cleaned monthly including deep cleaning of showers. Additionally, aides were to clean the showers daily after resident use.Interview with Housekeeping Supervisor (HKS) #808 on 03/11/26 at 9:57 A.M. revealed the facility contracts with an outside company for laundry, floor care and housekeeping staff. Housekeeping staff are expected to complete the following tasks daily: clean all resident rooms (empty trash, restock paper, towels, toilet paper, wipe horizontal surfaces, clean bathroom the sweep and mop floor), clean offices and all common areas including shower rooms. One full-time housekeeper was assigned for each of the two units in the facility, one full-time laundry aide, one full-time floor care worker and one full-time additional housekeeper to assist with office and common areas. HKS #808 additionally revealed daily she will check on the status of housekeeping employees at midday and at the end of the shift will pick one common area to spot check.Interview with the Director of Nursing (DON) on 03/11/26 at 10:11 A.M. confirmed all residents on the [NAME] Unit had potential to use the [NAME] shower room. No residents were only bed bath status. All residents were offered and had ability to use the shower. Interview on 03/11/26 at 11:16 A.M. with Resident #7 revealed during her last shower she saw mold in the shower, reported it to the aide the shower needs to be cleaned and needed an overhaul. On 03/11/26 at 11:25 A.M. an interview with Resident #28 revealed she was aware of the condition of the shower on the [NAME] unit because she heard in resident council that there was mold in that shower and maintenance painted over the mold in the past, but it was an ongoing issue.Interview on 03/11/26 at 11:40 A.M. with Housekeeper (HK) #809 revealed being routinely assigned to the [NAME] Unit. HK #809 stated they clean the shower room best as they can, the shower does not come completely clean, and they thought maintenance repaired the air vent about 6 months ago.Interview on 03/11/26 at 2:10 P.M. with Certified Nursing Assistant (CAN) #814 and (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA #815 revealed each CNA had reported to administration (names not provided) that the [NAME] Unit shower room has had black areas on the ceiling and walls, and the shower room had no ventilation.Review of facility document [NAME] Housekeeping Routine (7:00 A.M. to 3:00 P.M.) revealed the shower room was included in the shift cleaning responsibilities.Review of the facility policy titled Homelike Environment, dated February 2021, revealed facility characteristics include a clean, sanitary and orderly environment.This deficiency represents noncompliance investigated under Complaint Number 2794998.