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	05/29/2026

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 facility policy review, the facility failed to ensure resident rights were maintained. This affected one Resident (#43) out of 11 residents reviewed for resident rights. The facility census was 74.Findings include:Review of medical record for Resident #43 revealed an admission date of 10/10/25 and his diagnoses included chronic kidney disease, hypertension, and dependence on renal dialysis. Review of Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #43 had intact cognition, and no behaviors were identified.Review of care plan last revised 05/05/26 revealed Resident #43 had a behavior problem related to demanding medications for immediate administration, attention seeking, verbal aggression, swearing towards staff, and making false allegations. Interventions included adjusting voice tone; behavior contract given; caregivers to provide opportunities for positive interaction and attention; stop and talk with him when passing by; intervene as necessary to protect rights of others; speak in a calm manner; take to an alternate location as needed; and move to a less stimulating environment. There was nothing in the care plan regarding not allowing Resident #43 on the [NAME] Unit. Review of Resident #43's behavior contract dated 05/05/26 revealed over the past six months Resident #43 had displayed negative behaviors that had affected residents around him, the staff designated to care for him, and his roommate's ability to receive care. The plan listed as tools the resident could utilize: the facility concern form process, the Administrator and/or Director of Nursing (DON) were available to discuss concerns, and he refused to see psychological services. There was nothing in the behavioral contract regarding restricting him from a specified unit or staff to call the police if he did not leave a unit, especially if Resident #43 was calm and demonstrating no behaviors. Review of care plan last revised 05/06/26 revealed Resident #43 demonstrated verbally abusive behaviors related to coping skills, mental illness, poor impulse control as the resident belittled staff while yelling at staff in hallways. Interventions included adjusting voice tone; assess and anticipate needs; assess resident's coping skills and support system; allow time for resident to express self and feelings toward the situation; and when resident becomes agitated intervene before agitation escalates, guide away from source, engage calmly in conversation if response was aggressive the staff was to walk calmly away and approach later. There was nothing in the care plan regarding restricting Resident #43 on the [NAME] Unit. Interview on 05/19/26 at 8:51 A.M. with Resident #43 revealed an incident occurred on Sunday, 05/03/26, as he was supposed to have pain medication around 2:45 A.M. and it was 4:10 A.M. He looked for the nurse as he was in significant pain from a bad tooth. He finally found the nurse (Licensed Practical Nurse #620) on the other unit, [NAME] Unit, and asked her what was up with not getting his pain medication. He stated they got into an altercation because she had said she was not giving him his pain medication and then she called the police. The police came and then he received his pain medication. He revealed that he knew Registered Nurse (RN) #648 was scheduled to come in on 05/03/26 at 7:00 A.M., so he went to talk to her on the [NAME] Unit as he stated he always talked to her every morning that she worked. He started to talk with RN #648 when Licensed Practical Nurse (LPN) #620 stated to get off the unit or that she would call the police. LPN #620 repeated it a few (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	times. He stated, She threatened me, as he revealed he had never said anything to LPN #620 when he walked onto the unit and felt it was against his right that he could not be on the unit when he was just talking with RN #648. He stated that LPN #620 was no longer on duty as RN #648 had relieved her, so he did not understand why he did not have the right to be on the unit but indicated he left the unit. Interview on 05/19/26 at 10:09 A.M. with RN #648 revealed when she came on duty LPN #620 was at the medication cart, and she was awaiting to receive report from LPN #620 when Resident #43 walked onto [NAME] Unit and started to talk with her. She used to work on his unit, and they had a good rapport so every morning he usually came over to talk to her when she came on duty. She stated Resident #43 had not said anything to LPN #620 when he came up to them and started to talk with her in a calm manner. LPN #620 immediately told him, You do not need to be over here. RN #648 revealed Resident #43 then stated in a calm manner he came over to talk to her (RN #648), and LPN #620 stated, If you do not leave, I am calling the police. RN #648 again stated that Resident #43 was calm and did not display any behavior. RN #648 stated, Yes I feel she (LPN #620) kind of threatened him as he was just on the unit talking with me and not doing anything. He then appeared upset and left the unit. She did not report the incident to management. Interview on 05/19/26 at 10:37 A.M. with LPN #620 revealed there was a night that there was an altercation with Resident #43 as he was yelling in the middle of the night and they contacted the police. Later in the morning he had come over to [NAME] Unit at shift change and started swearing at her and calling her names. She told him to go back on the other side. LPN #620 verified she had told him if he did not go to his side she was calling the police. She revealed she notified RN/Assistant Director of Nursing (ADON) #663 about the incident and that she had said I did wrong as she said she should have just been quiet and not tell him to go to the other side or that she was contacting the police if he did not leave. Review of Resident #43's nursing notes dated 05/03/26 revealed there was no documentation regarding Resident #43 going to the [NAME] Unit in the morning at change of shift swearing at LPN #620 and calling her names. Interview on 05/19/26 at 2:08 P.M. with RN/ADON #663 revealed she could not remember all the details of the incident on 05/03/26 as she had not slept well when she had received the phone call from LPN #620, but does remember LPN #620 contacting her stating something about Resident #43 was yelling at her and she thought she had asked LPN #620 if she yelled back as she had the tendency to. She was not sure if that was when she had stated she told him to leave the unit or she was calling the police. She had used that as an educational moment that she could not do that but was unsure as she did not remember the full conversation. RN/ADON #663 verified she had not investigated the incident any further after the phone call. Interview on 05/19/26 at 2:32 P.M. with DON verified it had not been reported to her by RN #648 or to any other management regarding Resident #43 being on [NAME] Unit and LPN #620 telling him to leave the unit or she was calling the police, or that RN #648 felt LPN #620 threatened Resident #43. Interview on 05/19/26 at 4:35 P.M. with Regional Nurse #696 and RN #648 who came into the facility to speak with this surveyor revealed Regional Nurse #696 stated RN #648 had not felt LPN #620 was threatening Resident #43. This surveyor read aloud her interview and after reading it, RN #648 stated, That is correct. Then Regional Nurse #696 stated to RN #648, I thought you said LPN #620 did not threaten him, and then RN #648 stated, Yes she did not threaten him. RN #648 then continued stating she felt it was Resident #43's home and he had the right to be on any unit and should not be told to leave the unit or if he did not the police would be called. RN #648 verified again Resident #43 was calm that morning and had not said anything to LPN #620. Review of facility policy labeled, Resident Rights Policy and Procedure, dated 2026 revealed the purpose of the policy was to ensure the preservation of every resident's right to a dignified exitance, self-determination, and communication with and access to persons and services inside and outside the facility. Every resident had the right to be treated with respect and dignity including the right to be free from any psychical or chemical restraints imposed for purposes of discipline or convenience. Also, each resident had the right to interact with members of the community both inside and outside of the facility. This deficiency represents non-compliance (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigated under Complaint Number 2991563 and is a recite to the complaint survey completed 03/25/26.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, interview, and review of facility policy, facility staff failed to report allegations of rights violations, misappropriation, neglect and/or abuse in a timely manner. This affected seven residents (Residents #18, #32, #43, #72, #75, #79 and #80) out of 11 residents reviewed for reporting of abuse and/or resident rights violations. This had the potential to affect 32 residents residing in the [NAME] Unit (Residents #1, #3, #4, #5, #6, #9, #12, #13, #16, #18, #21, #22, #27, #28, #33, #34, #35, #38, #39, #40, #42, #43, #47, #49, #51, #55, #60, #63, #68, #69, #72 and #73) and 25 residents (Residents #1, #3, #8, #11, #12, #15, #16, #27, #28, #31, #32, #36, #37, #39, #41, #42, #44, #46, #49, #54, #60, #69, #70, #72 and #73) identified on insulin. The facility census was 74.Findings include:1. Review of closed medical record for Former Resident #75 revealed an admission date of 08/26/25 and he passed away 10/25/25 at the facility under hospice services. His diagnoses included chronic obstructive pulmonary disease, schizophrenia, and chronic respiratory failure. There was nothing in his medical record regarding misappropriation including staff taking his bank card and/or leather jacket. Review of significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Former Resident #75 had impaired cognition. 2. Review of medical record for Resident #72 revealed an admission date of 12/12/25 and diagnoses including diabetes, difficulty walking and hyperlipidemia. There was nothing in his medical record regarding abuse including staff selling him drugs. Review of Quarterly MDS assessment dated [DATE] revealed Resident #72 had intact cognition. Interview on 05/20/26 at 3:17 P.M. with Resident #72 denied any abuse and/or any staff selling him drugs. 3. Review of medical record for Resident #43 revealed an admission date of 10/10/25 and his diagnoses included chronic kidney disease requiring dialysis, and cellulitis. Review of Quarterly MDS assessment dated [DATE] revealed Resident #43 had intact cognition. Interview on 05/20/26 at 3:15 P.M. with Resident #43 denied any allegations of abuse including staff selling him drugs. 4. Review of closed medical record for Former Resident #80 revealed an admission date of 04/17/25 and he had passed away on 04/13/26 under hospice services. His diagnoses included malignant neoplasm of the prostate, diabetes, and hypertension. There was nothing in his medical record regarding sexual abuse and/or misappropriation. Review of Quarterly MDS assessment dated [DATE] revealed Former Resident #80 had severe cognitive impairment. 5. Review of closed medical record for Former Resident #79 revealed an admission date of 05/08/25 and he passed away on 01/25/26 under hospice services. His diagnoses included liver cell carcinoma, cirrhosis of the liver, and hypertension. There was nothing in his medical record regarding sexual abuse and/or misappropriation. Review of Quarterly MDS assessment dated [DATE] revealed Former Resident #79 had intact cognition. 6. Review of medical record for Resident #18 revealed an admission date of 08/06/24 and his diagnosis included hypertension, and diabetes. There was nothing in his medical record regarding abuse including sexual and/or being propositioned for money. Review of Quarterly MDS assessment dated [DATE] revealed Resident #18 had impaired cognition.Interview on 05/20/26 at 3:10 P.M. with Resident #18 revealed he did not want to provide any details and/or be interviewed as he was not answering any questions. Interview on 05/19/26 at 11:29 A.M. with Licensed Practical Nurse (LPN) #675 revealed residents in the [NAME] unit had prolonged incontinence as residents were not changed for prolonged time as their wheelchair seat cushions were saturated. She revealed she reported the incident to Registered Nurse (RN)/Assistant Director of Nursing (ADON) #663, and Certified Nursing Assistant (CNA) #638 came in off duty and yelled at her for reporting the situation. She stated she did find it intimidating especially to come in when not scheduled. Interview on 05/20/26 at 2:12 P.M. with Resident #32 revealed Confidential Staff Member #701 had revealed to her several disturbing things that had occurred in the [NAME] Unit and she was concerned as many things were abusive. She revealed Confidential Staff Member (CSM) #701 had told her Former CNA (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#702 was having sex with two Former Residents #79 and #80, and CNA #610 was lifting her shirt and showing her breasts for money to residents on the [NAME] Unit. She revealed CSM #701 also told her CNA #638 was selling drugs at the facility as CSM #701 had told her she witnessed him selling drugs to Resident #43 at the local convenience store. She stated she was concerned regarding the safety of residents in the [NAME] Unit. Interview on 05/20/26 at 2:42 P.M. with CSM #701 stated she had a fear of retaliation and wanted to remain anonymous but was concerned regarding sexual abuse, selling of drugs and misappropriation occurring in the [NAME] Unit. She revealed Former CNA #702 was having sex with Former Residents #79 and #80 for money. Former Resident #80 went around stating Former CNA #702 was his girlfriend and that she had borrowed money from him as well. Former CNA #702 was terminated but continued to come and see Former Resident #80. Staff (Former CNAs #702, #703 and #704) took Former Resident #75's bank card before he passed and used his bank card as well as one of them took his leather jacket. She heard CNA #610 go up to Resident #18 and stated, If I show you my boobs will you give me 200 hundred dollars? She was at the local convenient store and witnessed CNA #638 sell drugs to Resident #43. When asked how she knew it was drugs she revealed past experience know what is going on. She revealed RN/ADON #663 had a relationship with CNA #638 so hard to report as once LPN #675 reported him for care concerns and he came up to the facility when he was off duty as RN/ADON #663 most likely told him and threatened the nurse and stated, I had to come to work to check a {explicit}. Also, CSM #701 revealed CNA #684 was selling drugs to Residents #43 and #72. She revealed there was intimidation, so nobody reported anything as it was an unsafe work environment. She did not feel comfortable reporting the allegations as once she filed a grievance and was written up the next day as it was what the facility did, especially if reporting, they come after the person that reported not the person that was abusing the residents. She did not feel comfortable going to anyone at the facility to report and was not aware how to report any other means including anonymous. She verified she had told Resident #32 the concerns that were occurring in the [NAME] Unit. She was unable to provide exact dates of when these events had taken place, but stated she felt sexual abuse, selling of drugs, and misappropriation was still occurring especially since some staff remain at the facility and work in the [NAME] unit. Interview on 05/20/26 at 4:20 P.M. with Administer from other Facility #700, Regional Nurse #696, Director of Nursing (DON) and Administrator were notified of the above allegations. Interview on 05/21/26 at 7:45 A.M. with Regional Nurse #696 revealed they went through previous self-reported incidents (SRIs) and were not aware of the above allegations as the allegations had not been reported prior to 05/20/26 and there were no previous investigations. Interview on 05/26/26 at 9:52 A.M. with Regional Nurse #696 and Human Resources #685 revealed there was a corporate compliance hotline that was available 24 hours a day staff could report any allegation including anonymous and that it was reviewed upon hire. They revealed the above allegations were not reported on the hotline. 7. Review of medical record for Resident #32 revealed an admission date of 10/05/23 and diagnoses included diabetes, anemia, depression and cellulitis. Review of Quarterly MDS dated [DATE] revealed Resident #32 was cognitively intact and received insulin. Review of care plan dated 07/17/26 revealed Resident #32 had diabetes. Interventions included medications as ordered, dietary consult, and discussing mealtimes, portion sizes, and dietary restrictions.Review of May 2026 Physician orders and Medication Administrator Record (MAR) revealed Resident #32 had the following orders: check blood sugar before meals at 7:00 A.M., 11:00 A.M. 4:00 P.M. and at bedtime (9:00 P.M.); and provide Humalog insulin subcutaneous (SC) (a rapid acting insulin) per sliding scale coverage based on the blood sugar. On 05/13/26 Former Licensed Practical Nurse (LPN) #649 documented Resident #32's blood sugar at 7:00 A.M. as 256 and that he administered eight units of Humalog insulin (SC) per sliding scale. He documented her blood sugar at 11:00 A.M. as 290 and he administered eight units of Humalog insulin SC per sliding scale. He documented at 4:00 P.M. Resident #32 refused her blood sugar check and possible sliding scale coverage. Review of blood sugar summary for Resident #32 revealed on 05/13/26 it was documented at 8:30 A.M. Former LPN #649 obtained her blood sugar, and it was 256 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and the next time her blood sugar was taken was 3:20 P.M. and it was 290. There was no dinner blood sugar documented. Interview on 05/18/26 at 12:05 P.M. with Resident #32 revealed she recently spoke with Ombudsman #698 as she had a concern on 05/13/26 that Former LPN #649 did not administer her first dose of insulin until late afternoon around 4:30 P.M. She was to have her blood sugar checked at breakfast, lunch and dinner but that Former LPN #649 never checked her breakfast or lunch blood sugar and/or gave her insulin if needed per her sliding scale. She revealed the first time he came in was at 4:30 P.M. and at that time he checked her blood sugar and gave her insulin. She questioned him why he had not given her breakfast or lunch insulin and he had stated he was tied up and could not get to her sooner. She revealed then at 5:30 P.M. (one hour later) he had attempted to come back into the room to check her blood sugar and give her insulin as he stated the 4:30 P.M. dose was her lunch dose, and he was now doing the dinner check. She revealed she told him he cannot do that and refused as she was not taking the insulin that close together for fear of bottoming out her blood sugar. She reported the incident to several nurses including RN #648, and LPN #620 as she felt this was neglectful as she was concerned if he was doing this to other residents that may not be cognitively intact to know the difference. Interview on 05/18/26 at 1:00 P.M. with DON revealed she was not aware of any times Resident #32 did not receive her insulin as ordered as the incident on 05/13/26 was not reported to her. Interview on 05/18/26 at 2:02 P.M. with Ombudsman #698 revealed Resident #32 had brought up regarding not getting her insulin as ordered. Interview on 05/18/26 at 3:37 P.M. with RN #648 revealed Resident #32 had reported to her that Former LPN #649 had not given her insulin on 05/13/26. She did not report the incident as she thought the certified nursing assistant (CNA) had but was not sure of the name of the CNA. Interview on 05/19/26 at 10:37 A.M. with LPN #620 revealed Resident #32 had reported to her that Former LPN #649 did not check her morning or lunch blood sugar and/or administer her insulin. She did not report the incident as she thought Resident #32 was going to report it. She verified Resident #32 was upset and that she did state that she felt Former LPN #649 was an unsafe nurse to be working at the facility. Interview on 05/20/26 at 11:15 A.M. with Former LPN #649 revealed he was new at the facility and was just getting a routine down but the last day he worked, 05/13/26, he verified he obtained Resident #32's morning blood sugar before breakfast and administered her insulin but was not able to get to her lunch blood sugar check and possible insulin coverage until around 2:00 P.M. or 3:00 P.M He revealed Resident #32 did not appear upset until he had gone back before dinner to check her blood sugar again and she felt it was too soon and refused. He verified the blood sugar at lunch was to be checked before lunch at 11:00 A.M. and he was three to four hours late on checking and administering her insulin. He stated, It was just the course of the day as he got behind. He verified he did not contact the DON and/or physician that the blood sugar and/or insulin was not administered on time. He revealed when he worked at the facility, management did not help when he got behind so really there was nothing else he could have done. 8. Review of medical record for Resident #43 revealed an admission date of 10/10/25 and his diagnoses included chronic kidney disease, hypertension, and dependance on renal dialysis. Review of Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #43 had intact cognition, and no behaviors were identified.Review of care plan last revised 05/05/26 revealed Resident #43 had a behavior problem related to demanding medications for immediate administration, attention seeking, verbal aggression, swearing towards staff, and making false allegations. Interventions included adjusting voice tone; behavior contract given; caregivers to provide opportunities for positive interaction and attention; stop and talk with him when passing by; intervene as necessary to protect rights of others; speak in a calm manner; take to an alternate location as needed; and move to a less stimulating environment. There was nothing in the care plan regarding not allowing Resident #43 on the [NAME] Unit. Review of Resident #43's behavior contract dated 05/05/26 revealed over the past six months Resident #43 had displayed negative behaviors that had affected residents around him, the staff designated to care for him, and his roommate's ability to receive care. The plan listed as tools the resident could utilize: the facility (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	concern form process, the Administrator and/or Director of Nursing (DON) were available to discuss concerns, and he refused to see psychological services. There was nothing in the behavioral contract regarding restricting him from a specified unit or staff to call the police if he did not leave a unit, especially if Resident #43 was calm and demonstrating no behaviors.Review of care plan last revised 05/06/26 revealed Resident #43 demonstrated verbally abusive behaviors related to coping skills, mental illness, poor impulse control as the resident belittled staff while yelling at staff in hallways. Interventions included adjusting voice tone; assess and anticipate needs; assess resident's coping skills and support system; allow time for resident to express self and feelings toward the situation; and when resident becomes agitated intervene before agitation escalates, guide away from source, engage calmly in conversation if response was aggressive the staff was to walk calmly away and approach later. There was nothing in the care plan regarding restricting Resident #43 on the [NAME] Unit.Interview on 05/19/26 at 8:51 A.M. with Resident #43 revealed an incident occurred on Sunday, 05/03/26, as he was supposed to have pain medication around 2:45 A.M. and it was 4:10 A.M. He looked for the nurse as he was in significant pain from a bad tooth. He finally found the nurse (Licensed Practical Nurse #620) on the other unit, [NAME] Unit, and asked her what was up with not getting his pain medication. He stated they got into an altercation because she had said she was not giving him his pain medication and then she called the police. The police came and then he received his pain medication. He revealed that he knew Registered Nurse (RN) #648 was scheduled to come in on 05/03/26 at 7:00 A.M., so he went to talk to her on the [NAME] Unit as he stated he always talked to her every morning that she worked. He started to talk with RN #648 when Licensed Practical Nurse (LPN) #620 stated to get off the unit or that she would call the police. LPN #620 repeated it a few times. He stated, She threatened me, as he revealed he had never said anything to LPN #620 when he walked onto the unit and felt it was against his right that he could not be on the unit when he was just talking with RN #648. He stated that LPN #620 was no longer on duty as RN #648 had relieved her, so he did not understand why he did not have the right to be on the unit but indicated he left the unit.Interview on 05/19/26 at 10:09 A.M. with RN #648 revealed when she came on duty LPN #620 was at the medication cart, and she was awaiting to receive report from LPN #620 when Resident #43 walked onto [NAME] Unit and started to talk with her. She used to work on his unit, and they had a good rapport so every morning he usually came over to talk to her when she came on duty. She stated Resident #43 had not said anything to LPN #620 when he came up to them and started to talk with her in a calm manner. LPN #620 immediately told him, You do not need to be over here. RN #648 revealed Resident #43 then stated in a calm manner he came over to talk to her (RN #648), and LPN #620 stated, If you do not leave, I am calling the police. RN #648 again stated that Resident #43 was calm and did not display any behavior. RN #648 stated, Yes I feel she (LPN #620) kind of threatened him as he was just on the unit talking with me and not doing anything. He then appeared upset and left the unit. She did not report the incident to management.Interview on 05/19/26 at 10:37 A.M. with LPN #620 revealed there was a night that there was an altercation with Resident #43 as he was yelling in the middle of the night and they contacted the police. Later in the morning he had come over to [NAME] Unit at shift change and started swearing at her and calling her names. She told him to go back on the other side. LPN #620 verified she had told him if he did not go to his side she was calling the police. She revealed she notified RN/Assistant Director of Nursing (ADON) #663 about the incident and that she had said I did wrong as she said she should have just been quiet and not tell him to go to the other side or that she was contacting the police if he did not leave.Review of Resident #43's nursing notes dated 05/03/26 revealed there was no documentation regarding Resident #43 going to the [NAME] Unit in the morning at change of shift swearing at LPN #620 and calling her names.Interview on 05/19/26 at 2:08 P.M. with RN/ADON #663 revealed she could not remember all the details of the incident on 05/03/26 as she had not slept well when she had received the phone call from LPN #620, but does remember LPN #620 contacting her stating something about Resident #43 was yelling at her and she thought she had asked LPN #620 if she yelled back as she had the (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tendency to. She was not sure if that was when she had stated she told him to leave the unit or she was calling the police. She had used that as an educational moment that she could not do that but was unsure as she did not remember the full conversation. RN/ADON #663 verified she had not investigated the incident any further after the phone call.Interview on 05/19/26 at 2:32 P.M. with DON verified it had not been reported to her by RN #648 or to any other management regarding Resident #43 being on [NAME] Unit and LPN #620 telling him to leave the unit or she was calling the police, or that RN #648 felt LPN #620 threatened Resident #43.Interview on 05/19/26 at 4:35 P.M. with Regional Nurse #696 and RN #648 who came into the facility to speak with this surveyor revealed Regional Nurse #696 stated RN #648 had not felt LPN #620 was threatening Resident #43. This surveyor read aloud her interview and after reading it, RN #648 stated, That is correct. Then Regional Nurse #696 stated to RN #648, I thought you said LPN #620 did not threaten him, and then RN #648 stated, Yes she did not threaten him. RN #648 then continued stating she felt it was Resident #43's home and he had the right to be on any unit and should not be told to leave the unit or if he did not the police would be called. RN #648 verified again Resident #43 was calm that morning and had not said anything to LPN #620.Review of facility policy labeled, Resident Rights Policy and Procedure, dated 2026 revealed the purpose of the policy was to ensure the preservation of every resident's right to a dignified exitance, self-determination, and communication with and access to persons and services inside and outside the facility. Every resident had the right to be treated with respect and dignity including the right to be free from any psychical or chemical restraints imposed for purposes of discipline or convenience. Also, each resident had the right to interact with members of the community both inside and outside of the facility.Review of facility policy labeled, Residents Right to Freedom from Abuse, Neglect, and Exploitation, dated 2026 revealed residents were free from abuse, neglect, misappropriation of their property and exploitation. When the facility had identified abuse the facility would take all appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately, reporting the alleged violation and investigation within required timeframes pursuant to Federal and State statutes and regulations. This deficiency represents non-compliance investigated under Complaint Numbers 2991563 and 2993004 and is a recite to the complaint survey completed 04/20/26.

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	05/29/2026

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 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 record review, interview, review of a Self-Reported Incident (SRI) and facility policy, the facility failed to timely investigate into allegations that led to misappropriation of insulin. This affected four residents (Residents #12, #15, #16 and #32) out of five residents reviewed for misappropriation of their insulin. This had the potential to affect 25 residents (Residents #1, #3, #8, #11, #12, #15, #16, #27, #28, #31, #32, #36, #37, #39, #41, #42, #44, #46, #49, #54, #60, #69, #70, #72 and #73) identified on insulin. The facility census was 74.Findings include:1. Review of medical record for Resident #32 revealed an admission date of 10/05/23 and diagnoses included diabetes, anemia, cellulitis, and depression. Review of care plan last revised 07/18/25 revealed Resident #32 had diabetes. Interventions included medication as ordered, dietary consult for nutritional regimen with ongoing monitoring as needed, and discuss mealtimes, portion sizes, dietary restrictions as needed. Review of Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #32 had intact cognition and was on insulin.Review of May 2026 Physician Orders revealed Resident #32 had the following insulin orders: Lantus SoloStar Subcutaneous (SC) Solution Pen-injector 100 units per milliliter (ml) insulin, inject 38 units SC at bedtime due to diabetes; and Humalog Kwik pen SC solution pen-injector 100 units per ml, inject as per sliding scale before meals and at bedtime for diabetes. Interview on 05/18/26 at 12:05 P.M. and 05/20/26 at 2:12 P.M. with Resident #32 revealed she was concerned as she had heard nurses talking that they were sharing insulin needles between residents because they were out of insulin syringes and she was concerned regarding infection control if this was accurate. She discussed the concern with Licensed Practical Nurse (LPN) #620 who stated they were not sharing the pen needles, instead they were sharing the insulin pens between residents which Resident #32 still did not feel was safe, but LPN #620 stated she had no choice as the facility was out of insulin syringes. She revealed LPN #620 had stated they had used her insulin pens on others as well as other residents' insulin pens on her.2. Review of Resident #15's medical record revealed an admission date of 06/12/25 and his diagnoses included diabetes, hypertension and mood disorder. Review of care plan dated 06/23/25 revealed Resident #15 had diabetes. Interventions included medications as ordered, blood sugars as ordered and monitoring for signs of hyperglycemia and hypoglycemia. Review of Quarterly MDS assessment dated [DATE] revealed he had severe cognitive impairment and was on insulin. Review of May 2026 Physician Orders revealed Resident #15 had an order for Lantus Solostar SC solution pen-injector 100 units per ml insulin, inject 35 units SC every morning and bedtime due to diabetes.3. Review of Resident #12's medical record revealed an admission date of 07/31/14 and his diagnoses included diabetes, chronic kidney disease, and major depression. Review of care plan dated 07/02/25 revealed Resident #12 had diabetes. Interventions included medications as ordered, dietary consult for nutritional regimen with ongoing monitoring and monitoring for hypoglycemia and hyperglycemia symptoms. Review of Quarterly MDS assessment dated [DATE] revealed Resident #12 was cognitively intact and was on insulin. Review of May 2026 Physician Orders revealed Resident #12 had an order for Lantus insulin solution, inject 96 units SC in the morning due to diabetes.4. Review of the email dated 05/13/26 at 3:39 P.M. from Ombudsman #698 to Director of Nursing (DON) revealed Ombudsman #698 asked if the facility had insulin needles available to provide residents with insulin per doctor's orders and to please provide evidence that such was available for example a picture. Review of the email dated 05/13/26 at 4:05 P.M. from DON to Ombudsman #698 stated she verified that she spoke with Registered Nurse (RN)/ Assistant Director of Nursing (ADON) #663 who placed the supply orders and she stated the facility was never out. There were currently five boxes in the central supply room and an emergency supply in her office.Interview on 05/19/26 at 10:37 A.M. with LPN #620 revealed there was a week recently that the facility was out of insulin syringes; therefore, if a resident had a vial of insulin the nurses could not give the insulin. She stated the nurses had no choice but to borrow and administer insulin from (continued on next page)

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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	other residents that had insulin pens instead of the vials. She stated, We had no choice, I do not know who I borrowed from just went through the cart until found whoever I could find with the same insulin that the resident needed. LPN #620 verified she had used other residents' insulin on other residents for approximately one week until the supply of insulin syringes came in. She revealed she had notified RN/ADON #663 and she was aware the facility was out of insulin syringes and that the nurses were taking and using other residents' insulin. She stated all the nurses at the facility were doing it. LPN #620 revealed she most likely did take Resident #32's insulin or gave her someone else's insulin. Interview on 05/19/26 at 11:21 A.M. with LPN #674 revealed for about a week the facility was without insulin syringes and that she did take another resident's unopened insulin injection pen and administer it to another resident. She had placed that resident's name on the insulin pen. She could not remember whose insulin pen she took from and who she gave it to.Interview on 05/19/26 at 11:29 A.M. with LPN #675 revealed she had taken other residents' insulin to administer to other residents as residents did not have their insulin as ordered. She stated, I know it is wrong. I just do not really have a choice as they need their insulin. She revealed she knew she took Resident #12's insulin vial and gave it to Resident #15 or it was the other way around as one of them did not have any insulin. LPN #675 verified she had taken other residents' insulin and gave it to other residents but could not remember the exact residents she did. Interview on 05/19/26 at 2:08 P.M. with RN/ADON #663 revealed she completed the ordering of supplies including insulin syringes. She stated nobody had brought to her attention that the facility was out of syringes. She became aware of the concern about a week ago when Ombudsman #698 contacted the facility that a nurse had reported to them the facility was out of insulin syringes. She revealed the facility had syringes and she placed an extra box in her office that the nurses had access to as back up. She was not aware that nurses were taking and administering residents' insulin that belonged to another resident.Interview on 05/19/26 at 2:32 P.M. and 05/26/26 at 12:58 P.M. with DON revealed she had received notification from the Ombudsman #698 on 05/13/26 of concern of not having insulin syringes in the building and verified she did not interview any residents and/or nurses if there was a concern with not getting their insulin and/or not having insulin syringes to provide insulin as ordered and/or investigate further besides checking if the facility currently had insulin syringes. She revealed as of 05/26/26 they had investigated regarding nurses taking other residents' insulin and administering to other residents and LPN #620 and LPN #675 had stated they did. She did not have witness statements from the nurses as they had stated it verbally on investigation. She revealed LPN #620 and LPN #675 were terminated for misappropriation. Interview on 05/19/26 at 3:01 P.M. with Ombudsman #698 revealed it was reported to her by Resident #32 that the facility was out of insulin syringes and they were borrowing insulin pens from other residents. She revealed they sent the facility an email regarding the concern on 05/13/26.Review of SRI #274748 dated 05/19/26 at 8:34 P.M. revealed an SRI was filed by the Administrator regarding an allegation of misappropriation involving LPN #620 and LPN #675 taking insulin from Resident #12 and giving the insulin to another resident (Resident #16). The SRI revealed LPN #620 and LPN #675 took insulin from residents without their consent.Review of witness statement dated 05/22/26 at 11:33 A.M. with Resident #16 completed by Administrator from other Facility #700 revealed he could not get his insulin at one point because there were no syringes and he stated he did get it by the end of the day.Interview on 05/26/26 at 12:07 P.M. with Resident #16 revealed he missed his insulin one day as the facility did not have syringes and that he had an agency nurse. He stated the other days when they were out of insulin syringes the regular nurses took insulin from another resident and gave it to him, so he did not miss his insulin.Review of facility policy labeled, Resident Right to Freedom from Abuse, Neglect, and Exploitation, dated 2026 revealed residents were to be free from abuse, neglect, misappropriation of their property and exploitation. The facility would conduct a thorough investigation of the alleged violation. This deficiency represents non-compliance investigated under Complaint Number 2991563 and is a recite to the complaint survey completed 03/25/26.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of a Self-Reported Incident (SRI) and facility policy, the facility failed to provide insulin to residents using accepted standards of clinical practice. This affected four residents (Residents #12, #15, #16 and #32) out of five residents reviewed for diabetic care. This had the potential to affect 25 residents (Residents #1, #3, #8, #11, #12, #15, #16, #27, #28, #31, #32, #36, #37, #39, #41, #42, #44, #46, #49, #54, #60, #69, #70, #72 and #73) identified on insulin. The facility census was 74. Findings include:1. Review of medical record for Resident #32 revealed an admission date of 10/05/23 and diagnoses included diabetes, anemia, cellulitis, and depression. Review of care plan last revised 07/18/25 revealed Resident #32 had diabetes. Interventions included medication as ordered, dietary consult for nutritional regimen with ongoing monitoring as needed, and discuss mealtimes, portion sizes, dietary restrictions as needed. Review of Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #32 had intact cognition and was on insulin.Review of May 2026 Physician Orders revealed Resident #32 had the following insulin orders: Lantus SoloStar Subcutaneous (SC) Solution Pen-injector 100 units per milliliter (ml) insulin, inject 38 units SC at bedtime due to diabetes; and Humalog Kwik pen SC solution pen-injector 100 units per ml, inject as per sliding scale before meals and at bedtime for diabetes. Interview on 05/18/26 at 12:05 P.M. and 05/20/26 at 2:12 P.M. with Resident #32 revealed she was concerned as she had heard nurses talking that they were sharing insulin needles between residents because they were out of insulin syringes and she was concerned regarding infection control if this was accurate. She discussed the concern with Licensed Practical Nurse (LPN) #620 who stated they were not sharing the pen needles, instead they were sharing the insulin pens between residents which Resident #32 still did not feel was safe, but LPN #620 stated she had no choice as the facility was out of insulin syringes. She revealed LPN #620 had stated they had used her insulin pens on others as well as other residents' insulin pens on her. 2. Review of Resident #15's medical record revealed an admission date of 06/12/25 and his diagnoses included diabetes, hypertension and mood disorder. Review of care plan dated 06/23/25 revealed Resident #15 had diabetes. Interventions included medications as ordered, blood sugars as ordered and monitoring for signs of hyperglycemia and hypoglycemia. Review of Quarterly MDS assessment dated [DATE] revealed he had severe cognitive impairment and was on insulin. Review of May 2026 Physician Orders revealed Resident #15 had an order for Lantus Solostar SC solution pen-injector 100 units per ml insulin, inject 35 units SC every morning and bedtime due to diabetes. 3. Review of Resident #12's medical record revealed an admission date of 07/31/14 and his diagnoses included diabetes, chronic kidney disease, and major depression. Review of care plan dated 07/02/25 revealed Resident #12 had diabetes. Interventions included medications as ordered, dietary consult for nutritional regimen with ongoing monitoring and monitoring for hypoglycemia and hyperglycemia symptoms. Review of Quarterly MDS assessment dated [DATE] revealed Resident #12 was cognitively intact and was on insulin. Review of May 2026 Physician Orders revealed Resident #12 had an order for Lantus insulin solution, inject 96 units SC in the morning due to diabetes. 4. Review of the email dated 05/13/26 at 3:39 P.M. from Ombudsman #698 to Director of Nursing (DON) revealed Ombudsman #698 asked if the facility had insulin needles available to provide residents with insulin per doctor's orders and to please provide evidence that such was available for example a picture. Review of the email dated 05/13/26 at 4:05 P.M. from DON to Ombudsman #698 stated she verified that she spoke with Registered Nurse (RN)/ Assistant Director of Nursing (ADON) #663 who placed the supply orders and she stated the facility was never out. There were currently five boxes in the central supply room and an emergency supply in her office. Interview on 05/19/26 at 10:37 A.M. with LPN #620 revealed there was a week recently that the facility was out of insulin syringes; therefore, if a resident had a vial of insulin the nurses could not give the insulin. She stated the nurses had no choice but to borrow and administer insulin from other residents (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that had insulin pens instead of the vials. She stated, We had no choice, I do not know who I borrowed from just went through the cart until found whoever I could find with the same insulin that the resident needed. LPN #620 verified she had used other residents' insulin on other residents for approximately one week until the supply of insulin syringes came in. She revealed she had notified RN/ADON #663 and she was aware the facility was out of insulin syringes and that the nurses were taking and using other residents' insulin. She stated all the nurses at the facility were doing it. LPN #620 revealed she most likely did take Resident #32's insulin or gave her someone else's insulin. Interview on 05/19/26 at 11:21 A.M. with LPN #674 revealed for about a week the facility was without insulin syringes and that she did take another resident's unopened insulin injection pen and administer it to another resident. She had placed that resident's name on the insulin pen. She could not remember whose insulin pen she took from and who she gave it to. Interview on 05/19/26 at 11:29 A.M. with LPN #675 revealed she had taken other residents' insulin to administer to other residents as residents did not have their insulin as ordered. She stated, I know it is wrong. I just do not really have a choice as they need their insulin. She revealed she knew she took Resident #12's insulin vial and gave it to Resident #15 or it was the other way around as one of them did not have any insulin. LPN #675 verified she had taken other residents' insulin and gave it to other residents but could not remember the exact residents she did. Interview on 05/19/26 at 2:08 P.M. with RN/ADON #663 revealed she completed the ordering of supplies including insulin syringes. She stated nobody had brought to her attention that the facility was out of syringes. She became aware of the concern about a week ago when Ombudsman #698 contacted the facility that a nurse had reported to them the facility was out of insulin syringes. She revealed the facility had syringes and she placed an extra box in her office that the nurses had access to as back up. She was not aware that nurses were taking and administering residents' insulin that belonged to another resident. Interview on 05/19/26 at 3:01 P.M. with Ombudsman #698 revealed it was reported to her by Resident #32 that the facility was out of insulin syringes and they were borrowing insulin pens from other residents. Review of SRI #274748 dated 05/19/26 at 8:34 P.M. revealed an SRI was filed by the Administrator regarding an allegation of misappropriation involving LPN #620 and LPN #675 taking insulin from Resident #12 and giving the insulin to another resident (Resident #16). The SRI revealed LPN #620 and LPN #675 took insulin from residents without their consent. Interview on 05/20/26 at 11:38 A.M. with RN #635 revealed the last day she worked she heard the facility was out of insulin syringes. She had to borrow at times other residents' insulin for another resident as they were out but was unable to remember who she had borrowed from. Review of witness statement dated 05/22/26 at 11:33 A.M. with Resident #16 completed by Administrator from other Facility #700 revealed he could not get his insulin at one point because there were no syringes and he stated he did get it by the end of the day. Interview on 05/26/26 at 12:07 P.M. with Resident #16 revealed he missed his insulin one day as the facility did not have syringes and that he had an agency nurse. He stated the other days when they were out of insulin syringes the regular nurses took insulin from another resident and gave it to him, so he did not miss his insulin. Interview on 05/26/26 at 12:58 P.M. with DON revealed they had investigated regarding nurses taking other residents' insulin and administering it to other residents and LPN #620 and LPN #675 had stated they did. She stated she did not have witness statements from them as they had stated it verbally on investigation. LPN #620 and LPN #675 were terminated for misappropriation. Review of facility policy labeled, Administering Medications, dated April 2019 revealed insulin pens containing multiple doses of insulin are for single-resident use only. Changing the needle does not make it safe to use insulin pens for more than one resident.This deficiency represents non-compliance investigated under Complaint Number 2991563.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of facility policy, the facility failed to provide showers for residents dependent on staff for activities of daily living (ADL) per their preference and/or as scheduled. This affected two residents (Residents #25 and #70) out of three residents reviewed for ADL care. This had the potential to affect 35 residents (Residents #1, #3, #5, #8, #13, #15, #19, #20, #21, #22, #23, #24, #25, 27, #29, #32, #33, #42, #44, #47, #48, #49, #50, #54, #55, #56, #57, #59, #60, #62, #66, #69, #70, #71 and #72) dependent on staff for ADL care including showers. The facility census was 74. Findings include:1. Review of medical record for Resident #70 revealed an admission date of 05/21/25 and his diagnoses included diabetes, heart failure, major depression, and hypertension.Review of Kardex care plan dated 06/04/25 revealed Resident #70 required extensive assist from one staff for showers, and he was dependent on two staff assist for transfers with use of a mechanical lift (a device designed to transfer a resident from surface to surface).Review of Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #70 had intact cognition and required substantial to maximum assistance with showers and was dependent on staff for shower transfers. Review of task bar Bath/Shower documentation from 04/22/26 to 05/21/26 revealed Resident #70 was to receive a shower every Wednesday and Saturday in the evening. He received a partial bed bath on 04/22/26, and a bed bath on 04/24/26, 04/26/26, 05/03/26 (seven days after), 05/06/26, 05/09/26 and 05/21/26 (11 days after). Interview on 05/19/26 at 9:58 A.M. with Resident #70 revealed getting a bed bath and/or shower was an issue as he felt it had been over three weeks since his last bed bath/shower. He stated he preferred to have a shower twice a week as he felt with a bed bath staff did not get him clean enough, but that staff only would give him a bed bath. Observation at the time of the interview of Resident #70's ostomy bag revealed there was a brown, black substance surrounding the ostomy appliance and on the bag. 2. Review of medical record for Resident #25 revealed an admission date of 04/28/26 and his diagnoses included legal blindness, schizoaffective disorder, hypertension, and chronic pain syndrome.Review of task bar Bath/Shower documentation from 04/28/26 to 05/19/26 revealed Resident #25 was to receive a bath or shower every Tuesday and Friday morning. The documentation revealed he had a shower 05/05/26, 05/08/26, and a partial bed bath on 05/12/26. There was no documentation he had a shower or bath from 05/12/26 to 05/19/26 (seven days). Review of Medicare Five Day MDS assessment dated [DATE] revealed Resident #25 had impaired cognition and required partial to moderate assistance with showers and transfers. Review of Kardex care plan dated 05/05/26 revealed Resident #25 needed assistance from one staff for bathing, and transfers. Review of care plan dated 05/16/26 revealed Resident #25 had impaired visual function as he was legally blind. Interventions included to tell the resident where placing items and be consistent. Interview on 05/19/26 at 9:25 A.M. with Resident #25 revealed he was upset about his care as he was to receive a shower every Tuesday and Friday but that the aides would not assist him with one as he stated they do not help me. He revealed he preferred a shower twice a week and since he had been at the facility he had only received two in three weeks. Interview on 05/19/26 at 9:52 A.M. with Certified Nursing Assistant (CNA) #647, and CNA #631 revealed at times there were only two aides on the [NAME] Unit, and they could not get to all the assigned showers. They revealed there were times when they had up to eight showers a day and could not get them all done. Interview on 05/19/26 at 2:32 P.M. with Director of Nursing revealed staff documented in the electronic medical record all showers and baths per the task bar and they do not have shower sheets. Interview on 05/19/26 at 2:42 P.M. with CNA #651 revealed residents were not getting their showers or baths as scheduled as not enough staff and at times some of the aides do not do their showers. She revealed she went to the Former Administrator #699 regarding the concern of residents not getting their showers but felt as if she was attacked for bringing up the concern. Interview on 05/21/26 at 10:47 A.M. with Regional Nurse #696 verified Resident #70 was to have a (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shower every Wednesday and Saturday in the evening. She verified he went from 04/26/26 to 05/03/26 (seven days), and from 05/09/26 to 05/21/26 (11 days) without a shower. Also, she verified Resident #25's task bar Bath/Shower documentation from 04/28/26 to 05/19/26 revealed Resident #25 was to receive a bath or shower every Tuesday and Friday morning. The documentation revealed he had not had a shower or bath from 05/12/26 to 05/19/26 (seven days). Review of facility policy labeled, Activities of Daily Living (ADL), Supporting, dated March 2018 revealed residents would be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADLs. Appropriate care and services would be provided for residents who were unable to carry out ADLs independently with the consent of the resident and in accordance with the plan of care including hygiene (bathing). This deficiency represents non-compliance investigated under Complaint Number 2991563.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of facility policy, the facility failed to ensure ostomy care was provided as recommended. This affected two residents (Residents #70 and #77) out of three residents reviewed for ostomy care. This had the potential to affect five Residents (#36, #48, #61, #70 and #77) who the facility identified with ostomies. The facility census was 74.Findings include:1. Review of medical record for Former Resident (FR) #77 revealed an admission date of 02/13/24 and his diagnoses included hypotension, diabetes, chronic kidney disease, cerebral infarction, sepsis with acute organ dysfunction, septic shock, endocarditis, perforated bowel, history of cardiac arrest, and prolapsed ostomy.Review of care plan dated 08/07/25 revealed FR #77 had an alteration in gastrointestinal status related to colostomy. Interventions included empty ostomy bag each shift and as needed, give medications as ordered, monitor skin around stoma for irritation, sit upright for all meals and obtain and monitor lab work as ordered. There was nothing in his care plan regarding changing of his ostomy bag (a medical device worn outside the body to collect waste from the stoma, a surgically created opening in the abdomen) and or measuring the output. Review of care plan dated 12/12/25 revealed FR #77 had potential for pressure injury, a surgical wound, rash, cellulitis, skin tear, and vascular wound. Interventions included performing weekly skin assessments, reporting and documenting irregularities, protecting skin from moisture, encouraging adequate nutrition, evaluating and assessing pain control, and administering treatments as ordered. There was nothing in the care plan regarding an actual surgical incision with sutures to his abdomen. Review of April 2026 Treatment Administration Record (TAR) revealed no treatment order and/or documentation for his surgical incision with retention sutures (heavy, nonabsorbable stitches used in high-tension wound closures) that was recommended on his discharge instructions to cleanse with saline, apply an abdominal pad and tape with soft cloth adhesive. There also was no order on the TAR including for stoma assessment: inspect daily for color, edema, bleeding, or signs of ischemia, peristomal skin monitoring including monitor for breakdown, irritation, or infection and use barrier creams as needed. In addition, there was no order to monitor ostomy output that included recording volume, consistency, and frequency of effluent every shift and to notify the physician if high output of greater that 1200 milliliters (ml) per day, or sudden decrease or signs of obstruction as indicated in Nurse Practitioner (NP) #693's progress note dated 04/02/26. Review of admission Medicare Five Day Minimum Data Set (MDS) assessment dated [DATE] revealed FR #77 had intact cognition and he had an ostomy. He required substantial to maximum assistance with his toileting needs. Review of nursing note dated 04/01/26 at 8:01 P.M. and completed by Licensed Practical Nurse (LPN) #649 revealed at 6:30 P.M., FR #77 asked for help changing his ostomy bag for the fourth time during the shift and it had been ten minutes since the last change. There was no visible stool when the bag was removed but there was intestine exposed of approximately eight to ten inches. FR #77 denied pain and Emergency Rescue Squad (EMS) was contacted to send to the emergency room (ER). Review of After Visit Summary dated 04/02/26 revealed FR #77 was seen in the hospital for a prolapsed ostomy. The summary revealed past surgical history included on 07/28/25 of an exploratory laparotomy with total abdominal colectomy, and ileostomy due to peritonitis and septic shock. On 03/13/26 he had an exploratory laparotomy small bowel resection application of an active temporary abdominal closure system to manage open abdomen wounds (ABTHRA), and on 03/15/26 laparotomy exploratory surgery was performed. Hospital Admitting Physician #692 noted FR #77 was admitted due to a prolapsed stoma as he presented in the ER with approximately 7.5 inches to eight inches of stoma protruding from his abdomen. There was a one centimeter (cm) wound dehiscence (the splitting open of the surgical area) noted. The discharge instructions included wound care for his surgical wound to medial upper abdomen that was closed with retention sutures from laparotomy completed on 03/13/26. The (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	instructions included cleansing with saline, applying an abdominal pad and tape with soft cloth adhesive. Department of general surgery consulted due to the ostomy prolapse of eight inches of bowel was hanging out. The ostomy prolapse resolved on its own, his ostomy appeared healthy and he was having output from his ostomy. Review of NP #693 progress note dated 04/02/26 at 12:39 P.M. revealed she consulted due to status post hospitalization. The progress noted on assessment an abdominal surgical wound but no description of the wound. She recommended assessing for dehydration, including monitoring oral intake, monitoring ostomy output and signs of volume depletion as she may consider intravenous fluids if evidence of hypovolemia (abnormally low volume of circulating blood or fluid in the body). She ordered ostomy care and monitoring that included stoma assessment: inspect daily for color, edema, bleeding, or signs of ischemia. She also ordered peristomal skin monitoring including monitoring for breakdown, irritation, or infection and use of barrier creams as needed. In addition, she ordered to monitor ostomy output that included recording volume, consistency, and frequency of effluent every shift and to notify the physician if high output of greater than 1200 milliliters (ml) per day, or sudden decrease or signs of obstruction. Review of Skin Check Evaluation dated 04/04/26 completed by LPN #608 revealed FR #77 had an abrasion to the top of his scalp and an abrasion to his left hand. There was nothing on the assessment regarding his abdominal surgical incision with retention sutures. Review of Skin Check Evaluation dated 04/08/26 completed by LPN/Unit Manager #627 revealed FR #77 had a surgical incision to his abdomen. There was no description including measurement. Review of Skin Check Evaluation dated 04/15/26 and completed by LPN/Unit Manager #627 revealed FR #77 had a surgical incision to his abdomen. There was no description including measurement. Review of NP #694's progress note dated 04/15/26 at 10:13 P.M. revealed she consulted and noted his abdomen was non-tender and non-distended. He had an ileostomy and a mid-abdominal incision with bumper sutures (high tension wound closure to secure the area). There was no description of the incision site. Review of NP #693's progress note dated 04/16/26 at 4:15 P.M. revealed she consulted and noted he had an ileostomy and abdominal surgical incision. There was no description of the incision site. She continued to recommend assessing for dehydration, including monitoring oral intake, monitoring ostomy output and signs of volume depletion as she may consider intravenous fluids if evidence of hypovolemia. She continued to order ostomy care and monitoring that included stoma assessment: inspecting daily for color, edema, bleeding, or signs of ischemia. She also ordered peristomal skin monitoring including monitoring for breakdown, irritation, or infection and use of barrier creams as needed. In addition, she ordered to monitor ostomy output that included record volume, consistency, and frequency of effluent every shift and to notify the physician if high output of greater than 1200 ml per day, or sudden decrease or signs of obstruction. Review of nursing note dated 04/17/26 at 8:05 A.M. completed by LPN #632 revealed the nurse was called to the room as FR #77 was unresponsive and not able to be aroused. He was sent to the ER. Interview on 05/19/26 at 11:32 A.M. and 05/26/26 at 10:50 A.M. with Primary Care Physician (PCP) #695 revealed he was FR #77's physician and was aware of his abdominal incision but had not visibly assessed it. He verified per the hospital notes there was a one cm dehiscence of the surgical wound, and the discharge instructions included wound care for his surgical wound to the medial upper abdomen was to cleanse with saline, apply an abdominal pad and tape with soft cloth adhesive. He verified the facility should have been doing his surgical wound treatment at least daily. He also revealed they should have been at least changing his ostomy appliance weekly to twice a week or more often as needed, monitoring his output and emptying daily or more as needed. Interview on 05/21/26 at 9:09 A.M. with Registered Nurse (RN)/Assistant Director of Nursing (ADON)/Wound Nurse #663 revealed she oversaw wound care at the facility. She had an outside wound provider come in on a weekly basis to see all wounds including pressure and surgical. She verified FR #77 was not seen by the outside wound provider. She confirmed there was no assessment of the surgical wound including measurements, appearance, number of retention sutures and/or anything regarding the measurement of the wound dehiscence as noted in the hospital note. She verified the only skin (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessments in his record were on 04/04/26 which did not have that he had an abdominal incision, and on 04/08/26 and 04/15/26 it had that he had an abdominal incision but no description of it. She verified there was a treatment order on return from the hospital on [DATE] that included cleansing with saline, applying with an abdominal pad and taping with soft cloth adhesive, but it was not completed as ordered. She verified she usually sees all wounds, completes the measurements and assessments and ensures the resident had a treatment, but it was overlooked as in her position it was just a lot to keep up with wounds and infection control. Interview on 05/21/26 at 9:28 A.M. with LPN/Unit Manager #627 revealed she looked at the surgical wound but could not provide any details including measurements, how many sutures, if the area had dehisced, and/or any other description. She stated she recalled that his site was nothing out of the ordinary, and it was the RN/ADON/Wound Nurse #663 or outside wound provider who completed the measurements and description of the wounds. Interview on 05/21/26 at 10:10 A.M. with NP #693 verified she consulted and saw FR #77 during his stay at the facility. She was aware that he had a surgical incision to his abdomen and a ileostomy but had not seen and/or evaluated. She revealed she had seen him when he was outside on the patio and it was not appropriate to lift his shirt in that area. She verified the facility should have been following her orders including assessing for dehydration including monitoring oral intake, monitoring ostomy output and signs of volume depletion as she may consider intravenous fluids if evidence of hypovolemia. She also ordered ostomy care and monitoring that included stoma assessment: inspecting daily for color, edema, bleeding, or signs of ischemia. She ordered peristomal skin monitoring including monitoring for breakdown, irritation, or infection and use of barrier creams as needed. In addition, she ordered to monitor ostomy output that included recording volume, consistency, and frequency of effluent every shift and to notify the physician if high output of greater than 1200 ml per day, or sudden decrease or signs of obstruction.Interview on 05/21/26 at 11:54 A.M. with NP #694 verified she had seen FR #77 on 04/15/26 as she saw him mainly for his blood pressure that day. She revealed she did not complete a thorough assessment of his abdomen as he briefly lifted his shirt, and she noted no unusual complications including infections. She was unable to describe the incision, if the wound had dehisced, number of sutures, and/or its measurement. Interview on 05/26/26 at 11:44 A.M. with Regional Nurse #696 verified there was an order from the hospital on [DATE] that included cleansing with saline, applying an abdominal pad and taping with soft cloth adhesive. She also verified on the hospital record dated 04/02/26 there was documentation that the wound had a one cm dehiscence, and on return from the hospital there was no documentation that the treatment was completed as ordered and/or an assessment of the abdominal wound completed, including measurements, description, and number of sutures. She also verified there was no documentation regarding ileostomy care including NP #693's recommendations that included ostomy care and monitoring that included stoma assessment: inspecting daily for color, edema, bleeding, or signs of ischemia, peristomal skin monitoring including monitoring for breakdown, irritation, or infection and use of barrier creams as needed. In addition, there was no documentation regarding monitoring ostomy output that included recording volume, consistency, and frequency of effluent every shift and to notify the physician if high output of greater than 1200 ml per day, or sudden decrease or signs of obstruction. She also verified NP #693's recommendations to monitor ostomy output and signs of volume depletion as she may consider intravenous fluids if evidence of hypovolemia. 2. Review of medical record for Resident #70 revealed an admission date of 05/21/25 and his diagnoses included diabetes, heart failure, sepsis and hypertension. Review of care plan dated 06/04/25 revealed Resident #70 had an alteration in gastrointestinal status related to colostomy. Intervention included empty ostomy bag each shift and as needed, give medications as ordered, monitor for abdominal distention, and monitor skin around stoma for irritation. There was nothing in the care plan regarding changing the ostomy bag. Review of Physician Orders and Treatment Administration Records (TAR) for March 2026, April 2026 and May 2026 revealed there were no orders for Resident #70's ostomy bag including monitoring his stoma area, changing his bag and/or emptying (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his bag. There was no documentation when Resident #70's ostomy bag was last changed. Review of Quarterly MDS assessment dated [DATE] revealed Resident #70 had intact cognition and an ostomy. He required substantial to maximum assistance with his toileting needs. Interview and observation on 05/19/26 at 9:58 A.M. with Resident #70 revealed they only changed his ostomy appliance when it ruptured and/or fell off. He had been wearing the current ostomy bag for about one month as that was the last time they had changed it. He stated he was used to the ostomy bag being changed about weekly to twice a week but that was not what they did at this facility. Observation of the ostomy bag revealed it had dark brown, black substance surrounding the ostomy appliance and on the bag. Interview on 05/19/26 at 2:32 P.M. with Director of Nursing verified there were no colostomy orders including monitoring/assessing the stoma site, emptying colostomy bag, and/or changing of the colostomy bag. She verified she had no documentation as to when Resident #70's bag was changed last. Review of facility policy labeled, Colostomy/Ileostomy Care, dated October 2010 revealed the purpose of the procedure was to provide guidelines that aided in preventing exposure of the resident's skin to fecal matter. There was nothing in the policy regarding frequency of changing the ostomy bag, emptying the bag and checking the stoma area. The policy revealed the following information should be recorded in the resident's record: date and time the ostomy care was provided, if there were any breaks in the resident's skin, signs of infection, and/or excoriation of the skin.This deficiency represents non-compliance investigated under Complaint Number 2993004.

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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 observation, interview, record review and review of facility policy, the facility failed to ensure residents were free of significant medication errors. This affected two residents (Residents #32 and #73) out of eight residents reviewed for medication administration. The facility census was 74.Findings include:1. Review of Resident #73's medical record revealed an admission date of 12/22/25 and his diagnoses included chronic obstructive pulmonary disease (COPD), multiple sclerosis, hypertension, and peripheral vascular disease. Review of Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #73 had impaired cognition and received a diuretic (medication that help move extra fluids out of the body). Review of care plan dated 10/03/23 revealed Resident #73 had COPD. Interventions included monitoring for difficulty breathing, giving aerosol and inhalers as ordered, and monitoring for signs of respiratory infection. Review of May 2026 Physician Orders and May 2026 Medication Administration Record (MAR) revealed Resident #73 had the following orders: Lasix (diuretic) oral tablet 80 milligrams (mg) by mouth in the morning related to COPD dated 07/07/26 that was scheduled for 7:00 A.M.; and fluticasone propionate suspension 50 micrograms (mcg) per actuation (act) (pre-measured spray or puff), give one spray in each nostril one time a day for nasal congestion that was ordered for 8:00 A.M. Per the MAR he had not refused his nasal spray for the month of May 2026 from 05/01/26 to 05/19/26. Observation of medication administration on 05/19/26 at 8:11 A.M. completed by Agency Registered Nurse (RN) #697 revealed she obtained Resident #73's morning medications from the medication cart as ordered but omitted his fluticasone propionate suspension 50 mcg per act nasal spray and Lasix 80 mg tablet. She administered the medications, returned to the cart and signed off the medications as administered. Interview on 05/19/26 at 8:49 A.M. with Agency RN #697 after review of medication orders verified she had not given Resident #73 his fluticasone propionate suspension nasal spray 50 mcg per act as she stated he usually refused it. She verified that she had not offered or asked Resident #73 if he wanted it. She also verified she had not given Resident #73 his Lasix 80 mg tablet as she stated, I just missed it as she did not see the order. Interview on 05/19/26 at 9:19 A.M. with Resident #73 revealed he always took his nasal spray as he had allergies but that the nurse did not give it to him this morning. Review of nursing note dated 05/19/26 at 12:14 P.M. completed by RN/Assistant Director of Nursing (ADON) #663 revealed Nurse Practitioner (NP) #694 was notified that Resident #73 did not take his Lasix or fluticasone propionate suspension with his morning medications. NP #694 gave an order to give one time dose of Lasix 80 mg by mouth and fluticasone propionate suspension one spray each nostril. The medications were then administered. 2. Review of medical record for Resident #32 revealed an admission date of 10/05/23 and diagnoses included diabetes, anemia, depression and cellulitis. Review of Quarterly MDS assessment dated [DATE] revealed Resident #32 was cognitively intact and received insulin. Review of care plan dated 07/17/26 revealed Resident #32 had diabetes. Interventions included medications as ordered, dietary consult, and discussing mealtimes, portion sizes, dietary restrictions and ongoing monitoring. Review of May 2026 Physician orders and Medication Administrator Record (MAR) revealed Resident #32 had the following orders: check blood sugar before meals at 7:00 A.M., 11:00 A.M., 4:00 P.M. and at bedtime (9:00 P.M.); and provide Humalog insulin subcutaneous (SC) (a rapid acting insulin) per sliding scale coverage based on the blood sugar. On 05/13/26 Former Licensed Practical Nurse (LPN) #649 documented her blood sugar at 7:00 A.M. as 256 and that he administered eight units of Humalog insulin SC per sliding scale. He also documented her blood sugar at 11:00 A.M. was 290 and he administered eight units of Humalog insulin SQ per sliding scale. He documented at 4:00 P.M. Resident #32 refused her blood sugar check and possible sliding scale coverage. Review of blood sugar summary for Resident #32 revealed on 05/13/26 it was documented at 8:30 A.M. Former LPN #649 obtained her blood sugar, and it was 256 and the next time her blood sugar was taken was 3:20 P.M. and it was 290. There was no (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dinner blood sugar documented. Interview on 05/18/26 at 12:05 P.M. with Resident #32 revealed she recently spoke with Ombudsman #698 as she had a concern on 05/13/26 that Former LPN #649 did not administer her first dose of insulin until late afternoon around 4:30 P.M. She revealed she was to have her blood sugar checked at breakfast, lunch and dinner but that Former LPN #649 never checked her breakfast or lunch blood sugar and/or gave her insulin if needed per her sliding scale. The first time he came in was at 4:30 P.M. and at that time he checked her blood sugar and gave her insulin. She questioned him why he had not given her breakfast or lunch insulin, and he had stated he was tied up and could not get to her sooner. She revealed then at 5:30 P.M. (one hour later) he had attempted to come back into the room to check her blood sugar and give her insulin as he stated the 4:30 P.M. dose was her lunch dose, and he was now doing the dinner check. She told him he cannot do that and refused as she was not taking the insulin that close together for fear of bottoming out her blood sugar. She reported the incident to several nurses including RN #648, and LPN #620 as she felt this was neglectful as she was concerned if he was doing this to other residents that may not be cognitively intact to know the difference. Interview on 05/18/26 at 1:00 P.M. with Director of Nursing revealed she was not aware of any times Resident #32 did not receive her insulin as ordered. Interview on 05/18/26 at 2:02 P.M. with Ombudsman #698 revealed Resident #32 had brought up regarding not getting her insulin as ordered. Interview on 05/18/26 at 3:37 P.M. with RN #648 revealed Resident #32 had reported to her that Former LPN #649 had not given her insulin on 05/13/26. She stated she did not report the incident as she thought the certified nursing assistant (CNA) had but was not sure of the name of the CNA. Interview on 05/19/26 at 10:37 A.M. with LPN #620 revealed Resident #32 had reported to her that Former LPN #649 did not check her morning or lunch blood sugar and/or administer her insulin. She stated she did not report the incident as she thought Resident #32 was going to report it. Interview on 05/20/26 at 11:15 A.M. with Former LPN #649 revealed he was new at the facility and was just getting a routine down but the last day he worked, 05/13/26, he verified he obtained Resident #32's morning blood sugar before breakfast and administered her insulin but was not able to get to her lunch blood sugar check and possible insulin coverage until around 2:00 P.M. or 3:00 P.M. He stated she did not appear upset until he had gone back before dinner to check her blood sugar again and she felt it was too soon and refused. He verified the blood sugar at lunch was to be checked before lunch at 11:00 A.M. and he was three to four hours late on checking and administering her insulin. He stated, It was just the course of the day as he got behind. He verified he did not contact the Director of Nursing and/or physician that the blood sugar and/or insulin was not administered on time. He stated when he worked at the facility the management did not help when he got behind so really there was nothing else he could have done. Review of facility policy labeled, Administering Medications, dated April 2019 revealed medications were to be administered in a safe and timely manner as prescribed. Medications were to be administered in accordance with prescriber orders including required time frames. Medications were to be administered within one hour of prescribed time unless otherwise specified. The nurse administering the medication checks the label three times to verify right resident, right medication, right dose, right time, and right method. This deficiency represents non-compliance investigated under Complaint Number 2991563 and is a recite to the complaint surveys completed 03/25/26 and 04/20/26.

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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 had the potential to affect all 74 residents residing in the facility.Findings include:Review of the job description for Registered Nurse (RN)/Assistant Director of Nursing (ADON) revealed it was signed by RN/ADON #663 on 05/08/25. The position summary included the nurse would assist the Director of Nursing with management and training of the nursing services staff and the overall management of resident care; be aware of and adhere to residents' bill of rights; be aware of resident abuse reporting law; demonstrate availability to be on call 24 hours a day for nursing emergencies; make rounds upon entering the building each day; and be responsible for ensuring that nursing staff were aware of their job descriptions and the facilities expectations for resident care. There was nothing in the position summary regarding the ordering of supplies. Review of the job description for the Director of Nursing revealed it was signed by the DON on 10/02/25. The position summary included the nurse, under the supervision of the administrator, had 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, assumed responsibility for the facility; was responsible for the overall management of resident care 24 hours a day, seven days a week; conducted periodic reviews that the facility and personnel are in compliance with state code requirements; met with all licensed staff on a routine basis to review nursing and facility issues; ensured plans were in place to correct employee concerns; and was aware of resident abuse reporting law. Review of the job description for the Administrator revealed it was signed by the Administrator on 04/25/26. The position summary included under the direction of the regional vice president the Administrator led and directed the overall operations of the facility in accordance with resident needs, government regulations, and company polices to maintain quality of care for residents while achieving the facility business objectives; was aware of resident abuse reporting law; ensured understanding of, and compliance with all rules regarding residents' rights; and supervised, conducted and participated in department and facility education activities and staff meetings. During the onsite investigation, the following concerns related to the Administrator's, DON's, and RN/ADON #663's role responsibilities were identified: a. Review of the email dated 05/13/26 at 3:39 P.M. from Ombudsman #698 to DON revealed Ombudsman #698 asked if the facility had insulin needles available to provide residents with insulin per doctor's orders and to please provide evidence that such was available for example a picture.Interview on 05/19/26 at 10:37 A.M. with Licensed Practical Nurse (LPN) #620 revealed there was a week recently that the facility was out of insulin syringes; therefore, if a resident had a vial of insulin the nurses could not give the insulin. She stated the nurses had no choice but to borrow and administer insulin from other residents that had insulin pens instead of the vials. She stated, We had no choice, I do not know who I borrowed from just went through the cart until found whoever I could find with the same insulin that the resident needed. LPN #620 verified she had used other residents' insulin on other residents for approximately one week until the supply of insulin syringes came in. She revealed she had notified RN/ADON #663 and she was aware the facility was out of insulin syringes and that the nurses were taking and using other residents' insulin. She stated all the nurses at the facility were doing it. LPN #620 revealed she most likely did take Resident #32's insulin or gave her someone else's insulin.Interview on 05/19/26 at 11:21 A.M. with LPN #674 revealed for about a week the facility was without insulin syringes and that she did take another resident's unopened insulin injection pen and administer it to another resident. She had placed that resident's name on the insulin pen. She could not remember whose insulin pen she took from and who she gave it to.Interview on 05/19/26 at 11:29 A.M. with LPN #675 revealed she had taken other residents' insulin to administer to (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	other residents as residents did not have their insulin as ordered. She stated, I know it is wrong. I just do not really have a choice as they need their insulin. She revealed she knew she took Resident #12's insulin vial and gave it to Resident #15 or it was the other way around as one of them did not have any insulin. LPN #675 verified she had taken other residents' insulin and gave it to other residents but could not remember the exact residents she did.Interview on 05/19/26 at 2:08 P.M. with RN/ADON #663 revealed she completed the ordering of supplies including insulin syringes. She stated nobody had brought to her attention that the facility was out of syringes. She became aware of the concern about a week ago when Ombudsman #698 contacted the facility that a nurse had reported to them the facility was out of insulin syringes. She revealed the facility had syringes and she placed an extra box in her office that the nurses had access to as back up. She was not aware that nurses were taking and administering residents' insulin that belonged to another resident.Interview on 05/19/26 at 2:32 PM and 05/26/26 at 12:58 P.M. with DON revealed she had received notification from Ombudsman #698 on 05/13/26 of concern of not having insulin syringes in the building and verified she did not interview any residents and/or nurses if there was a concern with not getting their insulin as ordered and/or investigate further besides checking if the facility currently had insulin syringes. She stated as of 05/26/26 they had investigated regarding nurses taking other residents' insulin and administering to other residents and LPN #620 and LPN #675 had stated they did. She did not have witness statements from the nurses as they had stated it verbally on investigation. She revealed LPN #620 and LPN #675 were terminated for misappropriation. Interview on 05/19/26 at 3:01 P.M. with Ombudsman #698 revealed it was reported to her by Resident #32 that the facility was out of insulin syringes and they were borrowing insulin pens from other residents. They sent the facility an email regarding the concern on 05/13/26.Review of witness statement dated 05/22/26 at 11:33 A.M. with Resident #16 completed by Administrator from other Facility #700 revealed he could not get his insulin at one point because there were no syringes and he stated he did get it by the end of the day.Interview on 05/26/26 at 12:07 P.M. with Resident #16 revealed he missed his insulin one day as the facility did not have syringes and that he had an agency nurse. He stated the other days when they were out of insulin syringes the regular nurses took insulin from another resident and gave it to him, so he did not miss his insulin.b. Interview on 05/18/26 at 12:05 P.M. with Resident #32 revealed she recently spoke with Ombudsman #698 as she had a concern on 05/13/26 that Former LPN #649 did not administer her first dose of insulin until late afternoon around 4:30 P.M. She revealed she was to have her blood sugar checked at breakfast, lunch and dinner but that Former LPN #649 never checked her breakfast or lunch blood sugar and/or gave her insulin if needed per her sliding scale. The first time he came in was at 4:30 P.M. and at that time he checked her blood sugar and gave her insulin. She questioned him why he had not given her breakfast or lunch insulin, and he had stated he was tied up and could not get to her sooner. She revealed then at 5:30 P.M. (one hour later) he had attempted to come back into the room to check her blood sugar and give her insulin as he stated the 4:30 P.M. dose was her lunch dose, and he was now doing the dinner check. She told him he cannot do that and refused as she was not taking the insulin that close together for fear of bottoming out her blood sugar. She reported the incident to several nurses including RN #648, and LPN #620 as she felt this was neglectful as she was concerned if he was doing this to other residents that may not be cognitively intact to know the difference.Interview on 05/18/26 at 3:37 P.M. with RN #648 revealed Resident #32 had reported to her that Former LPN #649 had not given her insulin on 05/13/26. She stated she did not report the incident as she thought the certified nursing assistant (CNA) had but was not sure of the name of the CNA.Interview on 05/19/26 at 10:37 A.M. with LPN #620 revealed Resident #32 had reported to her that Former LPN #649 did not check her morning or lunch blood sugar and/or administer her insulin. She stated she did not report the incident as she thought Resident #32 was going to report it.Interview on 05/20/26 at 11:15 A.M. with Former LPN #649 revealed he was new at the facility and was just getting a routine down but the last day he worked, 05/13/26, he verified he obtained Resident #32's morning blood sugar before breakfast and (continued on next page)

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	365784	A. Building B. Wing	05/29/2026

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	administered her insulin but was not able to get to her lunch blood sugar check and possible insulin coverage until around 2:00 P.M. or 3:00 P.M. He stated she did not appear upset until he had gone back before dinner to check her blood sugar again and she felt it was too soon and refused. He verified the blood sugar at lunch was to be checked before lunch at 11:00 A.M. and he was three to four hours late on checking and administering her insulin. He stated, It was just the course of the day as he got behind. He verified he did not contact the Director of Nursing and/or physician that the blood sugar and/or insulin was not administered on time. He stated when he worked at the facility the management did not help when he got behind so really there was nothing else he could have done.c. Interview on 05/19/26 at 10:09 A.M. with RN #648 revealed when she came on duty LPN #620 was at the medication cart, and she was awaiting to receive report from LPN #620 when Resident #43 walked onto [NAME] Unit and started to talk with her. She used to work on his unit, and they had a good rapport so every morning he usually came over to talk to her when she came on duty. She stated Resident #43 had not said anything to LPN #620 when he came up to them and started to talk with her in a calm manner. LPN #620 immediately told him, You do not need to be over here. RN #648 revealed Resident #43 then stated in a calm manner he came over to talk to her (RN #648), and LPN #620 stated, If you do not leave, I am calling the police. RN #648 again stated that Resident #43 was calm and did not display any behavior. RN #648 stated, Yes I feel she (LPN #620) kind of threatened him as he was just on the unit talking with me and not doing anything. He then appeared upset and left the unit. She did not report the incident to management.Interview on 05/19/26 at 10:37 A.M. with LPN #620 revealed there was a night that there was an altercation with Resident #43 as he was yelling in the middle of the night and they contacted the police. Later in the morning he had come over to [NAME] Unit at shift change and started swearing at her and calling her names. She told him to go back on the other side. LPN #620 verified she had told him if he did not go to his side she was calling the police. She revealed she notified RN/Assistant Director of Nursing (ADON) #663 about the incident and that she had said I did wrong as she said she should have just been quiet and not tell him to go to the other side or that she was contacting the police if he did not leave.Interview on 05/19/26 at 2:08 P.M. with RN/ADON #663 revealed she could not remember all the details of the incident on 05/03/26 as she had not slept well when she had received the phone call from LPN #620, but does remember LPN #620 contacting her stating something about Resident #43 was yelling at her and she thought she had asked LPN #620 if she yelled back as she had the tendency to. She was not sure if that was when she had stated she told him to leave the unit or she was calling the police. She had used that as an educational moment that she could not do that but was unsure as she did not remember the full conversation. RN/ADON #663 verified she had not investigated the incident any further after the phone call.d. Interview on 05/19/26 at 10:37 A.M. with LPN #620 revealed there was a week recently that the facility was out of insulin syringes; therefore, if a resident had a vial of insulin the nurses could not give the insulin. She stated the nurses had no choice but to borrow and administer insulin from other residents that had insulin pens instead of the vials. She stated, We had no choice, I do not know who I borrowed from just went through the cart until found whoever I could find with the same insulin that the resident needed. LPN #620 verified she had used other residents' insulin on other residents for approximately one week until the supply of insulin syringes came in. She revealed she had notified RN/ADON #663 and she was aware the facility was out of insulin syringes and that the nurses were taking and using other residents' insulin. She stated all the nurses at the facility were doing it. LPN #620 revealed she most likely did take Resident #32's insulin or gave her someone else's insulin.Interview on 05/19/26 at 11:21 A.M. with LPN #674 revealed for about a week the facility was without insulin syringes and that she did take another resident's unopened insulin injection pen and administer it to another resident. She had placed that resident's name on the insulin pen. She could not remember whose insulin pen she took from and who she gave it to.Interview on 05/19/26 at 11:29 A.M. with LPN #675 revealed she had taken other residents' insulin to administer to other residents as residents did not have their insulin as ordered. She stated, I know it is wrong. I just (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	do not really have a choice as they need their insulin. She revealed she knew she took Resident #12's insulin vial and gave it to Resident #15 or it was the other way around as one of them did not have any insulin. LPN #675 verified she had taken other residents' insulin and gave it to other residents but could not remember the exact residents she did.Interview on 05/19/26 at 3:01 P.M. with Ombudsman #698 revealed it was reported to her by Resident #32 that the facility was out of insulin syringes and they were borrowing insulin pens from other residents.Review of witness statement dated 05/22/26 at 11:33 A.M. with Resident #16 completed by Administrator from other Facility #700 revealed he could not get his insulin at one point because there were no syringes and he stated he did get it by the end of the day.Interview on 05/26/26 at 12:07 P.M. with Resident #16 revealed he missed his insulin one day as the facility did not have syringes and that he had an agency nurse. He stated the other days when they were out of insulin syringes the regular nurses took insulin from another resident and gave it to him, so he did not miss his insulin.e. Interview on 05/19/26 at 11:29 A.M. with Licensed Practical Nurse (LPN) #675 revealed residents in the [NAME] unit had prolonged incontinence as residents were not changed for prolonged time as their wheelchair seat cushions were saturated. She revealed she reported the incident to Registered Nurse (RN)/Assistant Director of Nursing (ADON) #663, and Certified Nursing Assistant (CNA) #638 came in off duty and yelled at her for reporting the situation. She stated she did find it intimidating especially to come in when not scheduled. She did let RN/ADON #663 know what CNA #638 did but did not feel anything was done. f. She revealed Former CNA #702 was having sex with Former Residents #79 and #80 for money. Former Resident #80 went around stating Former CNA #702 was his girlfriend and that she had borrowed money from him as well. Former CNA #702 was terminated but continued to come and see Former Resident #80. Staff (Former CNAs #702, #703 and #704) took Former Resident #75's bank card before he passed and used his bank card as well as one of them took his leather jacket. She heard CNA #610 go up to Resident #18 and stated, If I show you my boobs will you give me 200 hundred dollars? She was at the local convenient store and witnessed CNA #638 sell drugs to Resident #43. When asked how she knew it was drugs she revealed past experience know what is going on. She revealed RN/ADON #663 had a relationship with CNA #638 so hard to report as once LPN #675 reported him for care concerns and he came up to the facility when he was off duty as RN/ADON #663 most likely told him and threatened the nurse and stated, I had to come to work to check a {explicit}. Also, CSM #701 revealed CNA #684 was selling drugs to Residents #43 and #72. She revealed there was intimidation, so nobody reported anything as it was an unsafe work environment. She did not feel comfortable reporting the allegations as once she filed a grievance and was written up the next day as it was what the facility did, especially if reporting, they come after the person that reported not the person that was abusing the residents. She did not feel comfortable going to anyone at the facility to report and was not aware how to report any other means including anonymous.g. Interview on 05/21/26 at 9:09 A.M. with RN/ADON/Wound Nurse #663 revealed she oversaw wound care at the facility. She had an outside wound provider come in on a weekly basis to see all wounds including pressure and surgical. She verified FR #77 was not seen by the outside wound provider. She confirmed there was no assessment of the surgical wound including measurements, appearance, number of retention sutures and/or anything regarding the measurement of the wound dehiscence as noted in the hospital note. She verified the only skin assessments in his record were on 04/04/26 which did not have that he had an abdominal incision, and on 04/08/26 and 04/15/26 it had that he had an abdominal incision but no description of it. She verified there was a treatment order on return from the hospital on [DATE] that included cleansing with saline, applying with an abdominal pad and taping with soft cloth adhesive, but it was not completed as ordered. She verified she usually sees all wounds, completes the measurements and assessments and ensures the resident had a treatment, but it was overlooked as in her position it was just a lot to keep up with wounds and infection control. She verified in her position she felt it was a lot to keep up with including wounds, infection control, ordering of supplies and the day-to-day oversight of operations. This deficiency represents non-compliance investigated under Complaint Number 2991563 and is a recite to the complaint survey completed 03/25/26.

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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, interview, and review of facility policy, the facility failed to ensure the medical record contained accurate information. This affected two residents (Residents #32 and #77) out of 11 records reviewed for documentation accuracy. The facility census was 74. Findings include:1. Review of medical record for Resident #32 revealed an admission date of 10/05/23 and diagnoses included diabetes, anemia, depression and cellulitis. Review of Quarterly MDS assessment dated [DATE] revealed Resident #32 was cognitively intact and received insulin.Review of care plan dated 07/17/26 revealed Resident #32 had diabetes. Interventions included medications as ordered, dietary consult, and discussing mealtimes, portion sizes, dietary restrictions and ongoing monitoring.Review of May 2026 Physician orders and Medication Administrator Record (MAR) revealed Resident #32 had the following orders: check blood sugar before meals at 7:00 A.M., 11:00 A.M., 4:00 P.M. and at bedtime (9:00 P.M.); and provide Humalog insulin subcutaneous (SC) (a rapid acting insulin) per sliding scale coverage based on the blood sugar. On 05/13/26 Former Licensed Practical Nurse (LPN) #649 documented her blood sugar at 7:00 A.M. as 256 and that he administered eight units of Humalog insulin SC per sliding scale. He also documented her blood sugar at 11:00 A.M. was 290 and he administered eight units of Humalog insulin SQ per sliding scale. He documented at 4:00 P.M. Resident #32 refused her blood sugar check and possible sliding scale coverage.Review of blood sugar summary for Resident #32 revealed on 05/13/26 it was documented at 8:30 A.M. Former LPN #649 obtained her blood sugar, and it was 256 and the next time her blood sugar was taken was 3:20 P.M. and it was 290. There was no dinner blood sugar documented.Interview on 05/18/26 at 12:05 P.M. with Resident #32 revealed she recently spoke with Ombudsman #698 as she had a concern on 05/13/26 that Former LPN #649 did not administer her first dose of insulin until late afternoon around 4:30 P.M. She revealed she was to have her blood sugar checked at breakfast, lunch and dinner but that Former LPN #649 never checked her breakfast or lunch blood sugar and/or gave her insulin if needed per her sliding scale. The first time he came in was at 4:30 P.M. and at that time he checked her blood sugar and gave her insulin. She questioned him why he had not given her breakfast or lunch insulin, and he had stated he was tied up and could not get to her sooner. She revealed then at 5:30 P.M. (one hour later) he had attempted to come back into the room to check her blood sugar and give her insulin as he stated the 4:30 P.M. dose was her lunch dose, and he was now doing the dinner check. She told him he cannot do that and refused as she was not taking the insulin that close together for fear of bottoming out her blood sugar. She reported the incident to several nurses including RN #648, and LPN #620 as she felt this was neglectful as she was concerned if he was doing this to other residents that may not be cognitively intact to know the difference. Interview on 05/18/26 at 2:02 P.M. with Ombudsman #698 revealed Resident #32 had brought up regarding not getting her insulin as ordered.Interview on 05/20/26 at 11:15 A.M. with Former LPN #649 revealed he was new at the facility and was just getting a routine down but the last day he worked, 05/13/26, he verified he obtained Resident #32's morning blood sugar before breakfast and administered her insulin but was not able to get to her lunch blood sugar check and possible insulin coverage until around 2:00 P.M. or 3:00 P.M. He stated she did not appear upset until he had gone back before dinner to check her blood sugar again and she felt it was too soon and refused. He verified the blood sugar at lunch was to be checked before lunch at 11:00 A.M. and he was three to four hours late on checking and administering her insulin. He stated, It was just the course of the day as he got behind. He verified he did not contact the Director of Nursing and/or physician that the blood sugar and/or insulin was not administered on time. He verified on the MAR he had inaccurately documented that he had checked her blood sugar and administered her insulin at 11:00 A.M. as ordered and the documentation was inaccurate as he had not obtained the blood sugar and/or provided her insulin until 2:00 P.M. or after. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of medical record for Former Resident (FR) #77 revealed an admission date of 02/13/24 and his diagnoses included hypotension, diabetes, chronic kidney disease, cerebral infarction, sepsis with acute organ dysfunction, septic shock, endocarditis, perforated bowel, history of cardiac arrest, and prolapsed ostomy.Review of care plan dated 12/12/25 revealed FR #77 had the potential for pressure injury, surgical wound, rash, cellulitis, skin tears, and vascular wounds. Interventions included performing weekly skin assessments, reporting and documenting any irregularities, and administer treatments as ordered. Review of nursing notes dated 03/31/26 at 3:42 P.M. completed by unknown agency nurse revealed FR #77 arrived back to the facility and he refused to allow the nurse to assess his skin, but FR #77 did mention he had a wound to his buttocks. Review of after visit summary dated 04/02/26 on the medication list there was no orders for arixtra (anti-coagulant), bumetanide (diuretic), and/or octreotide (treats severe diarrhea). Under the wound care documentation and therapy revealed he had an active sacrum wound that was described as a deep tissue injury that was dry and intact. On wound assessment dated [DATE] and 04/02/26 the area was denuded, pink, red, and the peri wound was fragile, edematous, with erosion and was warm. He also had a right BKA (below the knee amputation) pressure injury wound that was active. On assessment the wound was clean, dry and intact and the peri-wound was fragile. The wound instructions were to cleanse with saline and apply foam. Review of April 2025 Physician Orders, Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed arixtra 2.5 milligrams (mg) subcutaneous (SC) daily was discontinued on 04/02/26, bumetanide (diuretic) 0.5 mg by mouth every Monday, Wednesday, and Friday was discontinued on 04/02/26 and octreotide 50 micrograms (mcg) SC three time a day (active) for refractory high-output diarrhea was discontinued on 04/02/26. There was no treatment orders for wounds to his coccyx, left lateral foot, and right BKA stump. Review of admission Medicare Five Day MDS assessment dated [DATE] revealed FR #77 had intact cognition. He required substantial to maximum staff assistance with toileting hygiene, showers, and lower dressing. He required supervision with rolling left and right. Review of Nurse Practitioner (NP) #693's progress note dated 04/02/26 at 12:39 P.M. for FR #77 revealed she consulted due to status post hospitalization. The note revealed under review of systems he had a coccyx wound, left lateral foot wound, right BKA wound and abdominal surgical incision. The note revealed under physical exam: skin: warm, wound; other: coccyx, left lateral foot, right BKA stump, abdominal surgical incision. The progress note revealed to continue wound care for the chronic leg wound and monitor for secondary infection. Under medication management active medications relevant to chronic kidney disease was bumetanide 0.5 mg by mouth every Monday, Wednesday, and Friday (use with caution, monitor for hypovolemia, and electrolyte loss) and arixtra 2.5 mg SC daily (anticoagulation, monitor for bleeding risk especially with renal impairment). Under the medication and nutrition antidiarrheal therapy section NP #603 noted octreotide 50 mcg SC three times a day (active) for refractory high-output diarrhea. Review of Skin Check Evaluation dated 04/04/26 completed by LPN #608 revealed FR #77 had an abrasion to the top of his scalp and an abrasion to his left hand. There was nothing on the assessment regarding his abdominal surgical incision, wounds to his coccyx, left lateral foot, and right BKA. Review of Skin Check Evaluation dated 04/08/26 completed by LPN/Unit Manager #627 revealed FR #77 had a surgical incision to his abdomen. There was nothing on the assessment regarding wounds to his coccyx, left lateral foot, and right BKA. Review of NP #693 progress note dated 04/09/26 at 8:40 P.M. revealed she consulted for FR #77 as a follow up and noted under physical exam the skin was warm, wound, and under other: coccyx, left lateral foot, right BKA stump and abdominal surgical incision. Review of NP #693 progress note dated 04/13/26 at 10:47 P.M. revealed she consulted for FR #77 as follow up and noted under review of systems, skin: other: coccyx wound, left lateral foot, right BKA wound, abdominal surgical incision. Under physical exam she noted under skin, warm, wound, other: coccyx, left lateral foot, right BKA stump, abdominal surgical incision. Review of Skin Check Evaluation dated 04/15/26 completed by LPN/Unit Manager #627 revealed FR #77 had a surgical incision to his abdomen. There was nothing on the assessment (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regarding wounds to his coccyx, left lateral foot, and right BKA. Review of NP #693 progress note dated 04/16/26 at 9:07 P.M. revealed she consulted for FR #77 as follow up and revealed under physical exam, skin: warm, wound, other: coccyx, left lateral foot, right BKA stump, abdominal surgical incision. Interview on 05/21/26 at 9:09 A.M. with RN/ADON #663 revealed she was responsible for the wounds at the facility. She stated she had not looked at FR #77's coccyx, left lateral foot, and right BKA on return from the hospital on [DATE] to when he was sent to the hospital on [DATE]. She verified the nursing note dated 03/31/26 at 3:42 P.M. completed by unknown agency nurse revealed FR #77 arrived back to the facility and he refused to allow the nurse to assess his skin, but FR #77 did mention he had a wound to his buttocks. She verified on the after-summary consult dated 04/02/26 under the wound care documentation and therapy revealed he had an active sacrum wound that was described as a deep tissue injury that was dry and intact. On wound assessment dated [DATE] and 04/02/26 in the hospital the area was described as denuded, pink, red, and the peri wound was fragile, edematous, with erosion and was warm. He also had a right BKA pressure injury wound that was active. On assessment in the hospital on [DATE] and 04/02/26 the wound was clean, dry and intact and the peri-wound was fragile. The wound instructions were to cleanse with saline and apply foam. She revealed she can only go by the skin assessments completed on 04/04/26, 04/08/26 and 04/15/26 and the assessments did not have that FR #77 had wounds to his coccyx, left lateral foot, and right BKA. She verified NP #693 progress notes dated 04/02/26, 04/09/26, 04/13/26, and 04/16/26 all included that FR #77 had wounds to his coccyx, left lateral foot, and right BKA. She stated she felt these notes were inaccurate. Interview on 05/21/26 at 10:10 A.M. with NP #693 verified on her progress note dated 04/02/26 for FR #77 on return from the hospital the following under medication management active medications relevant to chronic kidney disease was bumetanide 0.5 mg by mouth every Monday, Wednesday, and Friday (use with caution, monitor for hypovolemia, and electrolyte loss) and arixtra 2.5 mg SC daily (anticoagulation, monitor for bleeding risk especially with renal impairment). Under the medication and nutrition antidiarrheal therapy section NP #603 noted octreotide 50 mcg SC three times a day (active) for refractory high-output diarrhea. NP #693 was asked if FR #77 was to continue these medications as listed in her progress note as they were not on the physician orders and/or MAR. She stated she does not put the medications into her progress note instead she uses artificial intelligence (AI) to pull the medications from one system to another and that it was a mistake as he was not to receive those medications per the after visit summary from the hospital. She revealed she did not see his skin including his coccyx, left lateral foot, and right BKA so she was unaware if he had those wounds. After reviewing her progress notes noted on 04/02/26, 04/09/26, 04/13/26, and 04/16/26 all included that FR #77 had wounds to his coccyx, left lateral foot, and right BKA, she stated again their system at times pulls from other systems (using AI) so it was possible he did not have these wounds, she was unsure. Review of facility policy labeled, Administering Medications, dated April 2019 revealed medications were to be administered in a safe and timely manner as prescribed. Medications were to be administered in accordance with prescriber orders including required time frames. Medications were to be administered within one hour of prescribed time unless otherwise specified. The nurse administering the medication checks the label three times to verify right resident, right medication, right dose, right time, and right method. If a drug was withheld, refused or given at a time other than the scheduled time the individual administering the medication shall initial and circle the MAR space provided for that drug or dose. Review of facility policy labeled, Charting and Documentation, dated July 2017 revealed the medical record should facilitate communication between the interdisciplinary team regarding the resident's response to care. Documentation in the medical record would be objective, complete and accurate. This deficiency represents non-compliance investigated under Complaint Number 2993004 and is a recite to the complaint surveys completed 03/25/26 and 04/20/26.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of the Centers for Medicare and Medicaid services (CMS) memorandum QSO-24-08-NH, and review of facility policy, the facility failed to utilize enhanced barrier precautions (EBP) for Resident #54 during high contact resident care. This affected one resident (Resident #54) out of two residents observed for EBP. This had the potential to affect 27 residents (Residents #1, #3, #5, #9, #10, #19, #20, #21, #31, #34, #36, #39, #41, #43, #45, #44, #48, #53, #54, #56, #60, #61, #66, #67, #69 #70 and #73) identified by the facility on EBP.Findings include:Review of medical record for Resident #54 revealed an admission date of 12/31/20 and her diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dysphagia, chronic obstructive pulmonary disease, and pulmonary edema. Review of care plan dated 10/07/25 revealed Resident #54 required EBP due to a feeding tube (a flexible tube inserted in the stomach to provide fluids and/or nutrition). Interventions included providing EBP including gloves, gown, mask, face shield for staff to wear during high contact resident care activities including dressing, bathing, hygiene care, assistance with toileting, and transferring. Review of Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #54 had impaired cognition and required a feeding tube. She required substantial to maximum assistance with toileting hygiene, upper body dressing, and personal hygiene. She was dependent on staff for lower dressing, bathing and/or showers. Review of May 2026 Physician Orders revealed Resident #54 had an order dated 05/23/25 for EBP due to feeding tube. Observation on 05/19/26 at 9:40 A.M. revealed Certified Nursing Assistant (CNA) #631, and CNA #647 entered Resident #54's room to provide morning hygiene and incontinence care. There was signage on the outside of the door that indicated she was on EBP as well as a bag hanging on the inside of the door with personal protective equipment (PPE) including gowns, gloves and masks. Resident #54 had an enteral feeding tube in her stomach that was connected to the feeding pump. CNA #631 and CNA #647 proceeded to perform hand hygiene and applied gloves. They did not apply a gown. CNA #631 and CNA #647 completed morning hygiene and incontinence care including rolling Resident #54 towards them and she came in direct contact with both their uniforms/clothing. They then doffed their gloves and performed hand hygiene. Interview on 05/19/26 at 9:52 A.M. with CNA #631 and CNA #647 verified there was signage on the doorway for Resident #54 to be on EBP and they did not apply a gown during her care. CNA #647 verified they were supposed to wear a gown especially because the resident had a feeding tube. Interview on 05/19/26 at 11:19 A.M. with Regional Nurse #696 verified anytime staff were providing high contact care including hygiene and incontinence care for Resident #54 they were to wear EBP including a gown as she had a feeding tube. Interview on 05/19/26 at 2:08 P.M. with Registered Nurse (RN)/Assistant Director of Nursing (ADON)/Infection Control #663 verified during high contact care activities EBP was to be worn including a gown for Resident #54 as she had a feeding tube. Review of the memorandum, QSO-24-08-NH, entitled Enhanced Barrier Precautions in Nursing Homes, dated 03/20/24, by the CMS, Department of Health & Human Services revealed EBP were indicated for residents with indwelling medical devices including feeding tubes even if the resident is not known to be infected or colonized with a multidrug-resistant organism (MDRO). EBP was an infection control measure designed to reduce transmission of MDRO and employs targeted gown and glove use during high contact care activities. High contact care activities included dressing, bathing, transferring, providing hygiene, changing incontinence products, and/or assisting with toileting. The effective date for implementation of EBP under the guidelines was 04/01/24.Review of facility policy labeled, Enhanced Barrier Precautions, dated 2021 revealed EBP were utilized to prevent the spread of MDRO to residents. EBP referred to infection prevention and control interventions designed to reduce transmission of MDRO during high contact care activities. EBP applied to residents even if not known to be infected with an MDRO but had a wound or indwelling device. Indwelling devices included (continued on next page)

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	05/29/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	central lines, urinary catheters, and feeding tubes. Gloves and a gown were to be applied prior to performing high contact resident care activities including dressing, bathing, transferring, providing hygiene, changing incontinence products, and/ or assisting with toileting. This deficiency represents non-compliance investigated under Complaint Number 2991563.