

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365818	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Bayley Place		STREET ADDRESS, CITY, STATE, ZIP CODE 990 Bayley Place Drive Cincinnati, OH 45233	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, policy review, and review of the 2022 United States Food and Drug Administration Food Code, the facility failed to ensure dietary staff wore appropriate hair (beard) covers while in the food preparation area. This had the potential to affect 104 of 104 residents who received meals from the kitchen, excluding Resident #1. The facility census was 105. Findings included: Observation on 08/11/25 at 11:16 A.M., during the initial tour, [NAME] #9 was observed in the food preparation area with long, facial hair that was approximately an inch in length, uncovered. Food Service Supervisor (FSS) #8 was also observed walking around the food preparation areas and counters, with facial hair approximately an inch in length, uncovered. Interview on 08/11/25 at 11:16 A.M., with the Director of Dining Services (DDS) stated they did not use the beard restraints unless the beard was especially long and drawn out. He gave no precise measurements on what the threshold would be. He confirmed the staff had just completed the lunch service. Interview on 08/14/25 at 10:16 A.M., with [NAME] #9 stated he had taken the beard restraint off during the initial tour observation. He stated he wore the beard restraint every day in the kitchen. Interview on 08/14/25 at 10:18 A.M., with FSS #8 stated that he normally wore beard restraints, and the policy stated they were required to wear beard restraints if they had facial hair. He stated that the Director of Dining Services (DDS) did not usually wear a beard restraint. He stated the staff only wore a beard restraint if their beard were the length of his beard or longer. Observation on 08/13/25 at 11:27 A.M., the Assistant Director of Nutrition (ADON) was observed in the food preparation areas with no beard restraint. He had facial hair that was approximately an eighth of an inch in length. Interview on 08/14/25 at 10:33 A.M., the ADN stated he had seen FSS #8 and [NAME] #9 in the kitchen without beard restraints, but they were usually supervising rather than preparing food and stated he only wore a beard restraint if he was preparing food, not necessarily if he was just in the kitchen. During a follow-up interview on 08/15/25 at 9:28 A.M., the DDS stated if staff could grasp their facial hair, they wore a beard restraint. Per the DDS, beard restraints were only worn in situations where the hair could fall in the food. He stated that hair restraints should be worn whenever staff were in food preparation areas, regardless of whether there was the potential that hair could fall into food. The DDS was unable to explain why there was a distinction between his expectation for hair restraints and beard restraints. The DDS stated that he wanted staff to put on a hair restraint prior to entering the kitchen. Interview on 08/15/2025 at 9:58 AM, the Executive Director (ED) stated that the facility should follow regulations regarding beard restraints. The ED stated it was her understanding that beard restraints were not necessary if the staff were not handling food. She stated this applied to hair restraints too. Review of the untitled policy, revised August 2018, indicated, A. When entering the kitchen all employees must wear a hair restraint properly. Examples include hair restraints, hats, and beard nets that cover body hair as applicable. B. Hair restraints to be worn effectively to keep hair from contacting exposed food, equipment, utensils, and linens. C. Hair restraints must always be worn when working in kitchens, pantries, or food prep areas. Review of the 2022 Food Code U.S. [United States] Food and Drug Administration, 01/18/23 version, indicated, (A) Except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on staff interview, record review, facility document and policy review, the facility failed to ensure a resident was provided a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN), Form CMS-10055. This affected one (#125) of three residents reviewed for beneficiary notices. The facility census was 105. Findings included: Based on interview, record review, facility document and policy review, the facility failed to ensure a resident was provided a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN), Form CMS-10055. This affected one (#125) of three residents reviewed for beneficiary notices. The facility census was 105. Findings included: Review of Resident #125's medical record revealed an admission date of 05/23/25. Resident #125's medical diagnoses included non-traumatic intracranial hemorrhage, abnormalities of gait and mobility, and unspecified convulsions. Review of the admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 05/30/25, revealed Resident #125 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated that the resident required substantial/maximum assistance from staff with bathing and dressing and set-up or clean-up assistance from staff for personal hygiene. Review of the list of residents discharged from a Medicare covered Part A stay with benefit days remaining during the prior six months revealed Resident #125 was discharged from a Medicare covered Part A stay on 06/20/25. Review of Resident #125's SNF [Skilled Nursing Facility] Beneficiary Notification Review form, completed by the facility, revealed the facility initiated Resident #125's discharge from Medicare Part A services when the resident's benefit days were not exhausted. The form indicated the resident's last covered day (LCD) under the benefit was 06/16/25. The form indicated the facility issued a CMS-10123 NOMNC but not a CMS-10055 SNF ABN. There was no documented evidence in the resident's record to indicate the resident was informed of the SNF ABN. Interview on 08/14/25 at 9:58 A.M., with Resident Services Coordinator (RCS) #5 stated she started her current position in June 2025. RCS #5 indicated she was not familiar with the SNF ABN document and had not provided it to Resident #125 when the resident decided to stay at the facility for a few days following the LCD. RCS #5 stated a representative from the billing department had the resident sign documents if the resident decided to continue their stay at the facility as a private pay resident. Interview on 08/14/25 at 10:42 A.M., with Accounts Receivable (AR) [NAME] Supervisor #17 stated Resident #125 only stayed for a few days following the LCD, so a full residency agreement was not completed, but a form was signed that acknowledged the private pay rate and services that were and were not covered. Interview on 08/14/25 at 11:33 A.M., with the Medical Records Coordinator (MRC) stated they were responsible for the NOMNC and SNF ABN forms being signed prior to RCS #5 beginning her position in June 2025. The MRC stated the SNF ABN form was not a form she was aware of, so she reached out to her consultant to receive education on how to use the form. The MRC stated she also was not completing the SNF ABN forms because she was not aware of the form. Interview on 08/14/25 at 3:50 P.M., with the Director of Nursing (DON) stated it was her expectation that the facility staff followed the CMS regulations and that the SNF ABN form be used when a resident was transitioning from Medicare Part A to private pay. During an interview on 08/14/25 at 4:03 P.M., with the Executive Director (ED) stated she was aware of the concerns related to the SNF ABN documents. The ED stated it was her expectation for the facility to be in regulatory compliance with the ABN notification, and the team had already begun correcting their process. Review of the policy titled, Advanced Beneficiary Notice, revised March 2025, revealed, To establish guidelines for the appropriate use of the Advanced Beneficiary Notice of Non-coverage (ABN) in compliance with CMS [Centers for Medicare and Medicaid Services] requirements, enabling residents and their representatives to make informed decisions regarding services Medicare may not cover. The policy continued, Appropriate ABNs will be provided before the facility begins providing the service. Sufficient time will be provided for the resident or resident representative to consider options and ask questions.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, record review, and policy review, the facility failed to ensure a preadmission screening and resident review (PASARR) level 1 was updated and resubmitted following the onset of a new mental illness diagnosis. This affected one (#13) of one residents reviewed for PASARR. The facility census was 105. Findings included: Review of Resident #13's medical record revealed an admission date of [DATE]. Resident #13's medical diagnoses included psychotic disorder with delusions (onset date [DATE]), major depressive disorder (onset date [DATE]), and anxiety disorder (onset date [DATE]). Review of the quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of [DATE], revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. The MDS indicated the resident had active diagnoses to include depression and psychotic disorder. Review of Resident #13's Care Plan Report included a problem statement dated [DATE] and revised [DATE], that indicated the resident used psychotropic medications due to depression, dementia with psychosis, psychotic disorder, sleep disorder, and anxiety. Review of Resident #13's record revealed no evidence to indicate a PASARR Level 1 was completed once the resident received a new mental illness diagnosis of psychotic disorder on [DATE], major depressive disorder on [DATE], or anxiety on [DATE]. Interview on [DATE] at 2:35 P.M., with Resident Services Coordinator (RSC) #16 stated he was not sure if there were any residents with an identified change where a new PASARR was warranted. RSC #16 stated normally, he learned about new serious mental illnesses during interdisciplinary team meetings, or nursing staff communicated a resident's new serious mental illness diagnosis to him. Interview on [DATE] at 10:11 A.M., with the Director of Nursing (DON) stated that she did not have much of a handle on PASARRs, and deferred questions on the subject to other staff. Interview on [DATE] at 9:58 A.M., with the Executive Director (ED) stated that for PASARRs, the RSC handled new resident reviews if there was a change of condition. The ED stated she did not know why staff did not complete a new PASARR Level 1 for Resident #13 after their new serious mental illness diagnoses, stating it must have slipped through the cracks. Review of the policy titled, PASARR, revised on [DATE], indicated, 5. PASARR is triggered by significant changes, expired convalescent/respite stays, psychiatric readmission, or extension requests.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, staff interviews, record review, and policy review, the facility failed to ensure the medication error rate was less than 5 percent (%). The facility had 2 medication errors out of 26 opportunities, resulting in a 7.69% medication error rate. This affected one (#96) of 11 residents reviewed during the medication task. The facility census was 105. Findings included: Review of Resident #96's medical record revealed an admission date of 02/26/15. Resident #96's medical diagnoses included anxiety disorder, major depressive disorder, dementia, and gastro-esophageal reflux disease (GERD). Review of Resident #96's Order Summary Report, dated 08/13/25, contained a physician order dated 03/18/24 for simethicone (an anti-flatulent) 80 milligrams (mg) by mouth three times a day. Observation of medication pass on 08/12/25 at 3:58 P.M., Licensed Practical Nurse (LPN) #2 administered simethicone 125 mg by mouth to Resident #96. Interview on 08/15/25 at 1:20 P.M., with LPN #2 stated she did not realize the brand of simethicone had changed and was a different dose than what was provided previously. LPN #2 stated she assumed the medication was the correct dose, and it was not. Observation of medication pass on 08/13/25 at 3:23 P.M., LPN #3 administered simethicone 125 mg by mouth to Resident #96. Observation and interview on 08/13/25 at 3:51 P.M., LPN #3 reviewed Resident #96's medication administration record (MAR) and stated the correct dose for simethicone was 80 mg. LPN #3 then looked at the box of simethicone and stated the medication in the box that was administered to the resident was 125 mg. LPN #3 stated 125 mg was not the ordered dose. Interview on 08/14/25 at 2:21 P.M., with the Assistant Director of Nursing (ADON) stated nurses were expected to verify the right patient, right time, right dose, and follow the rights of medication administration. The ADON stated the medications should be double checked before being administered. The ADON stated the unit manager was responsible for monitoring medications being administered. Interview on 08/14/25 at 2:47 P.M., with Nursing Supervisor (NS) #4 stated that nurses were expected to check the medication order, the medication dosage, assess the resident, and document the medication. NS #4 stated the pharmacy sent the wrong dose of simethicone, and the nurse did not check the dosage. NS #4 stated the nurse should have checked the dosage on the medication. NS #4 stated the family, doctor, and pharmacy were notified of the medication error, and there was no harm to the resident. NS #4 stated medications should be monitored each time they were given. Interview on 08/14/25 at 3:03 P.M., with the Director of Nursing (DON) stated the staff member training the new nurses was responsible for monitoring the nurses administering medications while in training. The DON stated after training the unit manager monitored medication administration, and the expectation was that nurses followed the five rights of medication administration. Interview on 08/14/25 at 3:19 P.M., the Executive Director (ED) stated the expectation was for nurses to follow the policy and procedure for medication administration, complete a safe medication pass, and follow the five rights of medication administration. The ED stated the pharmacist checked medication carts and monitored medication passes during their monthly visit. Review of the policy titled, Medication Administration, revised July 2025, revealed, 4. Medications are administered in accordance with prescriber orders, including any required time frame. The policy continued, 8. The individual administering the medications also checks the label to verify the right resident, right medication, right dosage, right time, and right route before giving the medication. This deficiency represents non-compliance investigated under Complaint Number 137881.		

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on record review, staff and physician interviews, and policy review, the facility failed to obtain laboratory test as ordered by the physician. This affected one (#13) of five residents reviewed for unnecessary medications. The facility census was 105. Findings included: Review of Resident #13's medical record revealed an admission date of 09/21/21. Resident #13's medical diagnoses included vascular dementia, psychotic disorder with delusions due to a known physiological condition, major depressive disorder, and anxiety disorder. Review of the quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 05/28/25, revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. Review of Resident #13's Care Plan Report, included a problem statement revised 06/05/25, that indicated the resident was at nutritional risk with potential for dehydration related to dementia, hypertension, acute ischemic cerebrovascular accident with left-sided weakness, altered labs, and decreased appetite. Interventions directed staff to obtain and monitor lab/diagnostic work as ordered and report results to the medical doctor. Review of Resident #13's Order Recap [Recapitulation] Report, for the timeframe from 07/03/25 through 08/31/25, contained an order dated 07/03/25, for TSH [thyroid-stimulating hormone]**WAITING to be Sent**. The Order Recap Report contained another order, dated 08/12/25, for TSH **SENT Uncollected 08/12/25 at 1:40 PM ET**. Review of Resident #13's Progress Notes, revealed a note dated 07/03/25 at 5:22 P.M., that indicated a fax was received from Medical Director (MD) #6 with new orders for a complete blood count, comprehensive metabolic panel, TSH, and urinalysis with culture and sensitivity. A Progress Note dated 08/12/25 at 1:42 PM, revealed, TSH not completed on 7/3. Notified [MD#6] with new order for TSH next lab day 8/13/25. Review of Resident #13's Lab Results Report, dated 08/13/25, revealed Resident #13's TSH was 1.640 mciu/mL (micro-international units per milliliter), which was within the reference range of 0.400 - 4.500 mciu/mL. Interview on 08/12/25 at 2:19 P.M., with the Assistant Director of Nursing (ADON) and the Executive Director (ED), the ADON stated the TSH level that was ordered on 07/03/25 was not completed and they did not realize it was missed until it was brought to their attention by the surveyor. The ADON stated the physician was notified and a new order was written. The ED stated that the facility should have identified ordered laboratory work that was not carried out within 24-48 hours. Interview via telephone on 08/12/2025 at 3:08 P.M., MD #6 stated the purpose of the TSH level for Resident #13 was just to follow up and make sure the TSH levels were where they needed to be. MD #6 stated she expected the nursing staff to follow physician orders as written. She said in this case, she was not worried about the delay in obtaining the lab because of the general clinical picture of the resident. Interview on 08/15/25 at 10:11 A.M., with the Director of Nursing (DON) stated that when a physician ordered a laboratory service, staff carried out the order by the date specified in that order. The DON stated that if there was no specified date, and it was a routine laboratory service, she expected a routine laboratory service to be carried out on the next day laboratory services were conducted. She stated that she did not know why Resident #13's TSH order was missed, but she suspected it was due to the laboratory service only recently integrating with the facility's electronic medical record (EMR). The DON stated that for whatever reason, there was miscommunication between the EMR and the laboratory service. The DON stated facility unit managers typically followed up on orders that were not completed. She stated that she was not sure why the unit managers missed it. Interview on 08/15/25 at 2:44 P.M., Nursing Supervisor (NS) #4 stated that it was the night shift unit managers who reviewed orders that might have been missed, and they did this on the night shift. She stated she was not sure why the TSH order for Resident #13 was missed. Interview on 08/15/25 at 9:58 A.M., the ED stated that physician orders should be carried out in a timely manner. The ED stated routine laboratory tests should be conducted within a day or two. The ED stated she believed the reason that Resident #13's TSH laboratory order was (continued on next page)		

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	missed was because the order was entered into the EMR, but for whatever reason, it did not cross over to their laboratory service from the EMR. The ED stated there was no specific policy on following physician orders. Review of the policy titled, Laboratory Services, reviewed 05/09/25, indicated, Laboratory services shall be performed by licensed, CLIA [Clinical Laboratory Improvement Amendments]- certified laboratories and in accordance with the physician's orders, facility protocols, and applicable regulations.		

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, staff interview, and policy review, the facility failed to ensure the survey results were posted in a location accessible to all residents, representatives, and visitors. This had the potential to affect all 105 of 105 residents who resided in the facility. Findings included: Observation on 08/12/25 at 3:30 P.M., of the facility revealed no evidence of a survey binder or signage indicating where the survey binder was located. Observation on 08/13/25 at 8:30 A.M., of the facility revealed no evidence of a survey binder or signage indicating where the survey binder was located. Observation and interview on 08/13/25 at 8:35 A.M., with the Executive Director (ED) revealed the survey binder was at the visitor sign-in kiosk located at the front entrance in a drawer. There were no signs observed indicating the survey binder was in the drawer at the kiosk or at the front desk. The ED stated they had just moved the binder from the Bistro to the new sign-in kiosk, and they did not have signs indicating the location of the survey binder, but people could ask where it was located. Interview on 08/13/25 at 9:22 A.M., with Receptionist #1 stated she had worked at the facility since 2019, and she was not aware of the survey results binder. She stated if someone asked her about the survey results binder, she would have to direct them to someone else who could help them locate the binder. Interview on 08/13/25 at 9:30 A.M., with Administrative Assistant (AA) #7 stated she did not know where the survey results binder was located prior to 08/13/25. AA #7 stated there was no signage that indicated the location of the survey results binder prior to her placing a sign that morning. Interview on 08/13/25 at 9:34 A.M., the Director of Nursing (DON) stated they had a survey result binder that was available for anyone who asked or requested to see it, and the binder contained their past survey results. The DON stated she was not aware of the current location of the survey results binder. She stated that typically it was accessible at the front desk upon request. She was not aware that the survey binder was to be readily available for anyone without having to ask for it. Interview on 08/13/25 at 9:41 A.M., the ED stated the survey result binder was available for residents, staff, visitors, or anyone. She stated anyone could ask a staff member or the receptionist where the survey binder was located and have access to it. The ED stated previously the binder was located on the counter in the Bistro, but since they had been renovating, they moved the survey results binder to the visitor kiosk located near the front entrance and did not have signs indicating the current location of the survey binder. Review of the policy titled, Access to Past Survey Results, revised March 2025, indicated, [Facility name] shall make available the most recent federal or state survey results in a public area that is accessible 24 x 7. Reports from the three preceding years, including deficiency statements and plans of correction, shall be made available for review upon request. A notice shall be displayed in public areas to inform residents, families, and visitors of this availability.		