STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365826	A. Building B. Wing	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Healthcare of Cuyahoga Falls	300 East Bath Road Cuyahoga Falls, OH 44223

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and review of facility policy, the facility failed to ensure the safe handling, transport, and separation of laundry to minimize the risk of exposure to contaminated items. This had the potential to affect all 65 residents who resided in the facility at the time of the survey.Findings include: Observation on 12/03/25 from 9:19 A.M. to 9:32 A.M. revealed one open laundry cart containing bags of soiled linen and one trash can labeled for placement of resident personal laundry. The observation revealed no bins or carts marked for laundry from isolation rooms or laundry that was heavily soiled with blood or bodily fluids. Further observation revealed one box of vinyl exam gloves sitting between two washing machines and no other personal protective equipment (PPE) was observed readily available for rinsing or sorting laundry. Interview on 12/03/25 at the time of the observation between 9:19 A.M. and 9:32 A.M. revealed Laundry Aide #859 verbalized not knowing whether there were any gowns, masks, goggles/face shields, or rubber gloves for handling and sorting contaminated laundry and further confirmed not ever wearing a gown or eye protection to sort or rinse contaminated linen. During the interview, Laundry Aide #859 verbalized there was non way to know whether laundry came from a room of a resident in contact or droplet isolation, or whether the linen was heavily soiled with blood or bodily fluids. Interview on 12/03/25 at 10:05 A.M. with Certified Nurse Aide (CNA) #818 revealed the facility used to place contaminated linen from isolation rooms in red biohazard bags, but none of the red biohazard bags had been seen on the unit for a while.Interview on 12/02/25 at 10:15 A.M wit CNA #816 revealed no education was received on how to handle soiled linen differently than other linen if from an isolation room or contaminated with blood or bodily fluids. Interview on 12/03/25 from 2:15 P.M. to 2:20 P.M. with Director of Support Services #806 verbalized that laundry staff would not be able to recognize laundry that was heavily contaminated, stating, it was not like they have a special bag to put that in. During the interview, Director of Support Services #806 reported that, to his knowledge, laundry staff were not trained on a specific protocol regarding gown, mask, or eye protection use when sorting or handling the soiled laundry. Observation of the soiled laundry room on 12/04/25 between 10:00 A.M. and 10:20 A.M. revealed no laundry aide, no running washing machines, and soiled laundry filled over the top of the laundry cart, many items noted to be unbagged and soiled with brownish stains, and some of the unbagged linen hanging out over the side of the laundry cart. Interview on 12/04/25 at 10:25 A.M. with Laundry Aide #859 confirmed having just arrived to the facility within the last five minutes and that, upon arrival, the laundry cart in the soiled laundry area was overflowing with soiled linen, and that several of the items, which appeared to come from multiple different rooms, were brought to the laundry room as loose, unbagged soiled items. During the interview, Laundry Aide #859 was observed wearing a pair of vinyl gloves, a long sleeve shirt/jacket with no gown, and was placing her arms into the cart containing soiled laundry while sorting out residents' personal laundry items and placing them in the appropriate container and then placing other soiled laundry into washing machines. Soiled linen was observed touching the laundry aides clothing (bilateral arms and front of the body) during the observation. At this time, Laundry Aide #859 confirmed wearing no gown and confirmed no knowledge of the facility providing laundry staff with rubber gloves or non-porous gloves when handling heavily soiled or soaked laundry and confirmed that the vinyl gloves did not protect further up the wrist or (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	lower arms while sorting the laundry during the observation. Interview on 12/04/25 from 10:40 A.M. to 10:55 A.M. with Assistant Director of Nursing (ADON) #822 confirmed soiled linen was to be bagged before leaving resident rooms and not to be carried through halls without being bagged. During the interview, ADON #822 also confirmed that she had spoken with the corporate office and was informed that linen soaked with blood or bodily fluids was to be placed in a red bag for transport to the laundry room. Review of the policy titled Laundry Services last revised February 2022 revealed soiled laundry was to be bagged at the point of care, prior to transport to the laundry room, and that linen soiled with blood or bodily fluids were to be placed in a red biohazard bag. Further review of the policy revealed protective barriers, such as fluid resistant gowns or aprons, gloves, masks, and face protection, should be readily available and appropriately used by laundry personnel. This deficiency is an example of continued non-compliance from the survey dated 11/19/25.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and review of the facility policy, the facility failed to ensure resident advance directives matched across paper and electronic medical records (EMR). This affected four residents (#8, #12, #32, #42) of four residents reviewed for advance directives. Facility census was 65.Findings include: 1.Review of Resident #12's medical record revealed an admission date of [DATE] and diagnoses including hemiplegia and hemiparesis following cerebral infarction, bilateral cataracts, seizures, unspecified protein-calorie malnutrition. Review of Resident #12's paper medical record on [DATE] revealed a bright yellow sheet indicating he had an advance directive of full code (where a patient has chosen to receive every possible life-saving treatment in the event of a cardiac or respiratory arrest. This means that if a patient's heart stops or they stop breathing, medical professionals will initiate immediate life-saving measures such as cardiopulmonary resuscitation (CPR)). Review of Resident #12's electronic medical record (EMR) as of [DATE] revealed he had an advance directive of Do Not Resuscitate Comfort Care (DNR-CC) dated [DATE] (where only comfort measures would be administered before, during, or after the time a patient's heart or breathing stops). The advance directive was also listed in a gray status bar under Resident #12's photo in the EMR. Review of a fascimile from Resident #12's hospice provider revealed an advance directive of DNR-CC signed [DATE]. Review of Resident #12's care plan revised [DATE] revealed Resident #12 had an advance directive of DNR-CC. Interventions listed included advanced directives will be placed on chart and Resident #12 and family have elected hospice care. Interview on [DATE] at 9:31 A.M. with Licensed Practical Nurse (LPN) #827 confirmed no advance directive was located in Resident #12's hospice binder. LPN #827 reviewed Resident #12's paper medical record in the presence of this surveyor and confirmed the yellow sheet with full code in his medical chart. LPN #827 then reviewed Resident #12's EMR in the presence of this surveyor and confirmed that record indicated Resident #12 had an advance directive of DNR-CC and the two charts did not match. Interview on [DATE] at 9:52 A.M. with the Director of Nursing (DON) revealed the facility was moving away from using paper charts. The DON was made aware of the above discrepancies with Resident #12's advance directive and she did not disagree. 2. Review of Resident #42's medical record revealed an admission date of [DATE] and diagnoses including heart failure, unspecified protein-calorie malnutrition, Wernicke's encephalopathy and alcohol abuse. Review of Resident #42's paper medical record as of [DATE] revealed no evidence of an advance directive. Review of Resident #42's EMR as of [DATE] revealed an advance directive of Do Not Resuscitate Comfort Care Arrest (DNR-CCA) dated [DATE] (where life-saving treatments are provided before a patient's heart or breathing stops. However, only comfort care is provided after that time). The advance directive was also listed in a gray status bar under Resident #42's photo in the EMR. Review of Resident #42's care plan dated [DATE] revealed Resident #42 had an advance directive of DNR-CCA. Interventions listed included maintain copy of code status on chart and make sure code status is signed and placed in clinical record. Interview on [DATE] at 9:31 A.M. with LPN #827 during review of Resident #42's paper medical record in the presence of this surveyor revealed no advance directive was found, so Resident #42 would be a full code in an emergency. LPN #827 then reviewed Resident #42's EMR in the presence of (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	this surveyor and confirmed that record indicated Resident #42 had an advance directive of DNR-CCA and the two charts did not match. Interview on [DATE] at 9:52 A.M. with the DON revealed the facility was moving away from using paper charts. The DON was made aware of the above discrepancies with Resident #42's advance directive and she did not disagree. 3. Review of the medical record for Resident #32 revealed an admission date of [DATE]. Diagnoses included chronic obstructive pulmonary disease, schizoaffective disorders, hypertension and panic disorder. Review of the Do Not Resuscitate form signed by Certified Nurse Practitioner on [DATE] indicated Resident #32 was a Do Not Resuscitate-Comfort Care. Review of the [DATE] orders revealed a DNR-CC No resuscitative measures even before cardiac and respiratory arrest ordered on [DATE]. Review of progress note dated [DATE] and timed at 5:20 P.M. revealed code status was updated. Resident and sister aware. Review of the hard chart revealed a FULL CODE page under Advance Directives. Interview on [DATE] at 9:10 A.M. with Assistant Director of Nursing #822 verified the FULL CODE form was in the hard chart and did not match the current order. 4. Review of the medical record for Resident #8 revealed an admission date of [DATE] and re-entry of [DATE]. Pertinent diagnoses included delusional disorders, generalized anxiety disorder, left knee pain, muscle wasting and atrophy, stage three chronic kidney disease, type two diabetes mellitus, unspecified protein-calorie malnutrition, chronic pain syndrome, contracture of multiple muscle sites, acute diastolic congestive heart failure, and repeated falls. Review of the Resident Census tab in the electronic medical record (EMR) revealed Resident #8 was on a hospital billable leave of absence from the facility from [DATE] to [DATE]. Review of the quarterly Minimum Data Set (MDS) completed on [DATE] revealed Resident #8 had intact cognition. Further review of the MDS revealed Resident #8 required staff setup or clean-up for eating and bathing but was independent for toileting hygiene, dressing, and personal hygiene. Review of the advanced directives in the hard (paper) chart on the nursing unit and in the EMR revealed Resident #8 had a DNR-CC order, dated [DATE]. Review of the active clinical orders in the EMR revealed two active code statuses (advanced directives on what medical interventions should be performed in the event of cardiac or respiratory arrest): 1) an order dated [DATE] for Resident #8 to be a full code (use of all life-saving measures, including cardiopulmonary resuscitation (CPR) and defibrillation), and 2) an order dated [DATE] for Resident #8 to be a Do Not Resuscitate – Comfort Care (DNR-CC, do not perform CPR if the heart stops or breathing ceases). Further review of the two code status orders revealed only one was signed by an ordering Provider, the order dated [DATE] for Resident #8 to be a full code in the event of cardiac or respiratory arrest. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on [DATE] at 12:15 P.M. with Licensed Practical Nurse (LPN) #803 confirmed there were two active, conflicting, code status orders in the EMR, one of which was signed by the Nurse Practitioner (for a full code), and the order dated [DATE] for a DNR-CC had not yet been signed. LPN #803 further confirmed there was a paper copy of the originally signed DNR-CC from [DATE] in the hard chart. During the interview, LPN #803 verbalized confusion and concern about what to do if Resident #8 went into cardiorespiratory arrest, since the belief was that Resident #8 was supposed to be a DNR, but the last signed order in the chart was for Resident #8 to be a full code. Interview with the Director of Nursing (DON) on [DATE] at 12:25 P.M. confirmed the order for Resident #8 to be a full code was signed and the DNR-CC order had not yet been signed by the ordering Provider. During the interview, the DON stated that since the last order regarding code status that was signed was for a full code, Resident #8 would be a full code, and CPR would have to be initiated in the event of cardiac or respiratory arrest until the facility obtained a signed order stating otherwise. Review of the policy titled Advance Directives, last revised [DATE], revealed that an advanced directives form was to be completed with the resident or the resident's legal representative upon admission, during reassessments, and with that quarterly care planning process, which included verification of the resident's code status. Further review of the policy revealed that a DNR order was not to be considered valid unless it included a physician's signature and that the DNR order should be placed in the resident's chart and then scanned and saved in the virtual medical record. The policy also indicated that the appropriate code status was to be recorded in the residents' physician orders.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records, facility policies and interviews the facility failed to ensure resident weights were recorded and monitored to ensure nutritional needs were met. This affected four residents (Residents #5, #38, #59, and #63) of five reviewed for nutrition. The facility census was 65.Findings include:1.Review of the medical record for Resident #5 revealed an admission date of 12/19/24. Diagnoses included but were not limited to schizoaffective disorder, unspecified dementia, adult failure to thrive, type II diabetes and unspecified severe protein-calorie malnutrition.Review of the 09/23/25 Minimum Data Set (MDS) 3.0 for Resident #5 revealed a Brief Interview of Mental Status (BIMs) of 8 which indicated moderate cognitive impairment. Resident #5 was noted to have require supervision with activities of daily living (ADLs) including meals. Resident #5 was noted to be on a physician prescribed weight gain program with a mechanically altered diet.Review of physician orders for Resident #5 revealed no order for weights to obtained.Review of the physician orders dated 05/30/25 revealed an order for observations each shift for behaviors for refusals of care including weight refusals. Document refusals and notify the physician as needed for behaviors.Review of the care last reviewed on 10/08/25 revealed Resident #5 is at increased risk for malnutrition as evidenced by underweight related to low body mass index. Interviews included monitor weight as provided. Notify nursing of any significant changes.Review of monthly weights for Resident #5 revealed no recorded weight for October 2025.Review of nursing progress notes for Resident #5 did not reveal any written evidence of weight refusal documented for October 2025.Phone interview on 12/03/25 at 2:00 P.M. Registered Dietitian (RD) #834 revealed she started with the facility in mid-September and is remote and has not been to the facility. RD #834 stated due to being remote, she has not been able to observe any of the residents she assesses, uses the food acceptance intake entered by staff and reviews their feeding ability entered by staff to complete the nutrition assessments. RD #834 stated nursing staff will give the staff a list for weights to be obtained and they will enter the weights in the medical record. RD #834 stated she monitors the weight remotely and pulls a weight report to chart on any identified weight concerns. RD #834 confirmed if a weight is not obtained it will not populate any concerns on the weight report and will not indicate a significant weight change would have occurred for one, three or six months if a weight is not recorded and weight trends may be missed for at least a month or longer until another weight is recorded. RD #834 stated if there is a weight discrepancy, she will contact the Director of Nursing (DON). RD #834 confirmed Resident #5 did not have a weight obtained in October 2025.2.Review of the medical record for Resident #38 revealed an admission date of 09/18/25. Diagnoses included but were not limited to anxiety disorder, unspecified dementia, paranoid personality disorder, delusional disorders and stage III chronic kidney disease.Review of the 09/30/25 admission Minimum Data Set (MDS) 3.0 for Resident #38 revealed a Brief interview of mental status (BIMs) of 6 which indicated severe cognitive impairment. Resident #38 was noted to require set up for meals. A height of 65 inches and weight of 108 pounds was noted.Review of physician orders for Resident #38 revealed no order for weights to be obtained.Review of the nutrition care plan initiated on 10/31/25 for Resident #38 revealed increased risk for malnutrition as evidenced by dementia, stage III chronic kidney disease and heart failure. Interventions listed included monitor weight as provided and notify nursing of any significant changes. Review of the weights for Resident #38 revealed no admission weight listed and two weights: a weight of 108.6 pounds (#) on 10/10/25 and a weight of 170.2 # on 11/14/25.Review of the Review of the admission nutrition assessment dated [DATE] revealed it was started but not finished. No weight or height were completed. In the summary section, the last known weight was listed as 170# from the hospital.Review of the nursing progress notes did not reveal evidence an admission weight was obtained, indication of the weight discrepancy from 10/10/25 to 11/14/25 or a reweight requested or obtained.Phone interview on 12/03/25 at 2:00 P.M. RD #834 revealed she started with (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the facility in mid-September and is remote and has not been to the facility. RD #834 stated due to being remote, she has not been able to observe any of the residents she assesses, uses the food acceptance intake entered by staff and reviews their feeding ability entered by staff to complete the nutrition assessments. RD #834 stated nursing staff will give the staff a list for weights to be obtained and they will enter the weights in the medical record. RD #834 stated she monitors the weight remotely and pulls a weight report to chart on any identified weight concerns. RD #834 confirmed if a weight is not obtained it will not populate any concerns on the weight report and will not indicate a significant weight change would have occurred for one, three or six months if a weight is not recorded and weight trends may be missed for at least a month or longer until another weight is recorded. RD #834 stated if there is a weight discrepancy, she will contact the DON but confirmed she was unable to provide evidence of correspondence with the DON regarding the significant weight loss for Resident #38 or other residents. RD #834 also confirmed she does not complete the MDS or nutrition care plans for residents.3.Review of the medical record for Resident #59 revealed an admission date of 04/20/23. Diagnoses included but were not limited to vascular dementia with behaviors, anxiety disorder, type II diabetes mellitus, unspecified protein-calorie malnutrition and dysphagia.Review of the 10/06/25 quarterly Minimum Data Set (MDS) 3.0 for Resident #59 revealed a Brief Interview of Mental Status (BIMs) of one which indicated severe cognitive impairment. Resident #59 was noted to required set up for eating. Resident #59 was noted to have a height of 60 inches and weight of 127# with no noted weight changes.Review of the physician orders for Resident #59 did not reveal an order for weights to be obtained.Review of the care plan last reviewed on 10/08/25 revealed Resident #59 was at increased risk for malnutrition as evidenced by diagnosis of weakness and muscle wasting and diuretic use with potential significant weight changes. Interventions included to monitor weights as provided and notify nursing of any significant weight changes.Review of the 07/09/25 quarterly mini nutrition assessment for Resident #59 revealed moderate decrease in food intake, weight loss between two to seven pounds and was indicated to be at risk for malnutrition.Review of weights recorded for Resident #59 indicated no weight recorded for October 2025.Review of the nursing progress notes revealed no noted refusal for weight in October 2025.Phone interview on 12/03/25 at 2:00 P.M. RD #834 revealed she started with the facility in mid-September and is remote and has not been to the facility. RD #834 stated due to being remote, she has not been able to observe any of the residents she assesses, uses the food acceptance intake entered by staff and reviews their feeding ability entered by staff to complete the nutrition assessments. RD #834 stated nursing staff will give the staff a list for weights to be obtained and they will enter the weights in the medical record. RD #834 stated she monitors the weight remotely and pulls a weight report to chart on any identified weight concerns. RD #834 confirmed if a weight is not obtained it will not populate any concerns on the weight report and will not indicate a significant weight change would have occurred for one, three or six months if a weight is not recorded and weight trends may be missed for at least a month or longer until another weight is recorded. RD #834 stated if there is a weight discrepancy, she will contact the DON. RD #834 confirmed Resident #59 did not have a weight obtained in October 2025.4.Review of the medical record for Resident #63 revealed an admission date of 09/12/25. Diagnoses included but were not limited to dementia with psychotic disturbance, unspecified protein-calorie malnutrition and paranoid schizophrenia.Review of the 09/25/25 admission Minimum Data Set (MDS) 3.0 for Resident #63 revealed a Brief Interview of Mental Status (BIMs) of 13 which indicated intact cognition. Resident #63 was noted to require set up for meals.Review of the physician orders for Resident #63 did not indicate an order for weights to be obtained.Review of the care plan dated 10/15/25 revealed no nutrition care plan for Resident #63.Review of the weights recorded for Resident #63 revealed an admission weight of 154# on 09/12/25, no weight recorded for October 2025 and a weight of 150.6# recorded on 11/04/25.Review of the nursing progress notes did not reveal a note related to a weight refusal for October 2025.Observation on 12/02/25 at 12:45 P.M. revealed Resident #63 feeding self. Interview was unable (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to be obtained due to cognitive impairment.Phone interview on 12/03/25 at 2:00 P.M. RD #834 revealed she started with the facility in mid-September and is remote and has not been to the facility. RD #834 stated due to being remote, she has not been able to observe any of the residents she assesses, uses the food acceptance intake entered by staff and reviews their feeding ability entered by staff to complete the nutrition assessments. RD #834 stated nursing staff will give the staff a list for weights to be obtained and they will enter the weights in the medical record. RD #834 stated she monitors the weight remotely and pulls a weight report to chart on any identified weight concerns. RD #834 confirmed if a weight is not obtained it will not populate any concerns on the weight report and will not indicate a significant weight change would have occurred for one, three or six months if a weight is not recorded and weight trends may be missed for at least a month or longer until another weight is recorded. RD #834 stated if there is a weight discrepancy, she will contact the DON. RD #834 confirmed Resident #63 did not have a weight obtained in October 2025.Review of the 06/2019 revised facility policy called Weighing the Resident revealed residents will be recorded and monitored at least monthly. Procedures included obtain weight and height on each patient/resident within twenty-four hours of admission and readmission. New admissions are to be weighed within 24 hours, then weekly times four weeks and then monthly and/or per physician's orders. If the month-to-month weight shows more than a five -percent gain or loss, the patient/resident is reweighed within 24 hours. The facility dietitian reviews the patient's/residents nutritional status and makes recommendations for interventions in the nutritional progress notes if significant weight change is noted.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility policy review and facility assessment review, the facility failed to ensure adequate staffing was provided for the memory care unit. This affected 20 residents (Residents #5, #11, #14, #19, #21, #22, #24, #31, #36, #38, #40, #41, #44, #46, #54, #57, #59, #61, #63 and #65) of 20 residents on the memory care unit. The facility census was 65. Findings include:Observation on 12/03/25 at 6:56 A.M. on [NAME] unit (memory care unit) revealed no staff present after completing a tour of the unit. Two residents were observed sitting on chairs sleeping in the common area and another resident was noted sitting in a chair sleeping by herself in the kitchen area. All other residents were observed to be in their rooms in their beds. Interview on 12/03/25 at 7:02 A.M. with Licensed Practical Nurse (LPN) #817 revealed she was just coming on shift and had not seen any of the night staff walking onto the unit and had not gotten report yet and confirmed staff should have been on the unit. Review of the staff time punches revealed CNA #810 worked from 6:44 P.M. on 12/02/25 till 7:03 A.M. on 12/03/25.Phone interview on 12/03/25 at 7:13 A.M. with Certified Nurse Aide (CNA) #810 confirmed she left the memory care unit at 6:50 A.M. to assist another resident outside of the unit due to her requesting no male aide care. CNA #810 confirmed she was off the unit about 10 minutes and came back to get her coat and left shift shortly after 7:00 A.M. CNA #810 confirmed there is usually just one aide on the memory care unit during the night shift and the nurse does a split shift with another unit and checks on the unit periodically. Interview on 12/03/25 at 7:20 A.M. with LPN #811 confirmed she worked the split covering both the Buckeye Unit which has 16 residents and the [NAME] (memory care) unit which has 20 residents. LPN #811 confirmed she had last been on the memory care unit around 6:45 A.M. before leaving to assist someone else and stated she was not aware CNA #810 had left the unit. LPN #811 stated they do not have walkie talkies and use the unit phone to call for assistance but if no one is at the desk, they will not be altered assistance is needed. LPN #811 stated at nighttime, it is hard to assist both units and will delay her medication pass to monitor residents on the memory care unit while the aide is putting residents to bed and if a resident requires a two-person assist, they have to wait for an CNA from another unit to come assist them and can delay care to residents.Interview on 12/03/25 at 3:25 P.M. with Assistant Director of Nursing (ADON) #822 revealed they review hours per patient day (PPD), and acuity for staffing schedules. ADON #822 confirmed there are supposed to be two people back on memory care at all times and confirmed there were not two staff on the memory care unit at the end of the night shift on the morning of 12/03/25. If the nurse is not on the unit, staff are supposed to call another CNA to cover and confirmed staff should not have left the memory care unit unattended. Interview on 12/04/25 at 6:46 A.M. with CNA #879 revealed there is usually only one aide on the night shift back in the memory care unit and will sometimes use her personal phone to contact staff if no one answers the unit phones when she needs assistance for two person residents. Interview on 12/04/25 at 6:58 A.M. with CNA #896 confirmed she does not feel there is enough staff on the night shift and is usually one aide on the night shift back on memory care. CNA #896 stated if the nurse has to leave another aide is supposed to come assist but it does not usually happen unless staff call for someone to assist.Interview on 12/04/25 at 7:07 A.M. with CNA #812 revealed during the night there is usually one only CNA on the memory care unit and they do not have walkie talkies and uses her personal phone to contact other staff since staff are not always at the nurses station to hear the call for assistance. CNA #812 stated staff are supposed to tell each other if they are leaving the unit but they are not always alerted or know when they need assistance on memory care. Interview on 12/04/25 at 7:15 A.M. with CNA # 903 revealed there is a resident on the split hall on night shift who requests no male caregivers so when a male works, they have to request another aide go to assist the resident and this sometimes involves the aide on memory care unit to assist. CNA #903 stated he will tell the (continued on next page)

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Continuing Healthcare of Cuyahoga Falls	300 East Bath Road Cuyahoga Falls, OH 44223

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	aide assistance is needed but is unable to stay due to having several of his own residents who are high risk and is afraid to leave them unattended for risk of fall as well. Interview on 12/04/25 at 11:07 A.M. with the Director of Nursing (DON) revealed they go by PPD and census for staffing and like to stay at 2.8-3.0 PPD. One day shift they usually have three nurses and five to six CNAs. Night shift usually has two nurses and three CNAs. For the memory care unit, they usually have two CNAs for day shift and one on night shift. DON stated they are supposed to have at least one CNA back in the memory care unit on night shift and the nurse will cover the split of the Buckeye unit and [NAME] (memory care) unit. DON confirmed they do not have alternate means of communications and staff are to use the unit phone to request assistance. DON confirmed there is always supposed to be two staff members on the memory care unit and if an aide needs to leave to assist of Buckeye for a female resident who requests no meals, the other aide should cover on memory care. DON stated staff are not supposed to use their personal phone to contact other staff. DON stated the facility assessment did not specify par staffing levels nor did it differentiate between the different units and levels of care. Review of 12/02/25 BIPPA revealed the night shift had two LPNs for a total of 24 hours, four CNAs for a total of 46 hours. The BIPPA did not differentiate between the different units and did not state specific staff coverage for the memory care unit. Review of the facility list of residents who require a two-person assist revealed 11 residents (Residents #2, #4, #7, #12, #21, #24, #27, #30, #36, #51, and #60) required a two-person assist including two residents (#21 and #24) who resided on the memory care unit. Review of the 01/2025 revised facility policy called; Contingency Staffing revealed the facility is committed to maintaining adequate staffing levels to ensure the safety and well-being of residents. The policy did not give specific staffing levels.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. Based on record review and interview, the facility failed to ensure Resident #15 was offered a care conference meeting quarterly or as needed. This affected one resident (Resident #15) of one reviewed for care conference meetings. The census was 65. Findings include: Review of the medical record for Resident #15 revealed and admission date of 02/12/25. Diagnoses included acute congestive heart failure, anxiety disorder and pyogenic arthritis. Review of the Minimum Data Set (MDS) 3.0 screen revealed assessments were done on 02/12/25, 02/18/25, 05/21/25, 8/21/25 and 11/20/25. Review of the quarterly MDS Set 3.0 dated 11/20/25 revealed she was cognitively intact. Review of the Care Plan meeting assessments revealed they were dated for 7/23/25, 5/27/25, 3/25/25 and 2/25/25. Review of the 07/23/25 form revealed Resident #15 attended. Interview on 12/03/25 at 4:50 P.M. with Social Service Designee (SSD) #924 verified the facility missed at least one care conference meeting with Resident #15 stating Resident #15's last care conference was 07/21/25. SSD #924 stated she had been covering as Activity Director since February 2025 along with her SSD/Marketing responsibilities. She stated they had hired two activity assistants within past month and the Activity Director in the past two weeks. SSD #924 stated she received the list of residents due for MDSs and would give the list to the receptionist who would send a letter to family and resident. Review of the facility policy titled Care Planning, last revised in June 2019, revealed every effort will be made to schedule care plan meetings to accommodate the availability of the resident and family or responsible party.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on medical record review, interview, review of the United States (U.S.) Food and Drug Administration (FDA) latest approved labeling information for Zyprexa, and review of facility policy, the facility failed to ensure antipsychotics were prescribed only as indicated and the resident was monitored appropriately for potential side effects. This affected one Resident (Resident #9) of seven residents who were reviewed for unnecessary medications. The facility census was 65. Findings include:Review of the medical record for Resident #9 revealed an admission date of 09/05/25. Pertinent diagnoses included Alzheimer's disease, unspecified dementia, severe, with agitation, mild depressive disorder, single episode, post-traumatic stress disorder (PTSD), altered mental status, and other symbolic dysfunctions (a variety of language and cognitive impairments).Review of the annual Minimum Data Set (MDS) 3.0 assessment completed on 09/10/25 revealed Resident #9 had severely impaired cognition and mild depression with no behaviors, wandering, or rejection of care. Further review of the MDS revealed Resident #9 had non-traumatic brain dysfunction, Alzheimer's disease, non-Alzheimer's dementia, anxiety disorder, depression not classified as bipolar, and PTSD and received medications from the high-risk drug categories of antipsychotic, antidepressant, diuretic, opioid, and anticonvulsant.Review of the current medications revealed an order dated 11/10/25 to 11/14/25 and again on 11/14/25 at 5:06 P.M. for Resident #9 to have olanzapine (Zyprexa, an atypical antipsychotic medication) two and a half milligrams (mg) by mouth at bedtime. Further review of Zyprexa orders revealed Resident #9 had an order from 06/09/25 to 11/10/25 for Zyprexa to be increased to five mg by mouth at bedtime from 2.5 mg by mouth at bedtime, which was ordered to be given from 04/21/25 to 06/09/25. Additional psychotropic medications noted around the time the Zyprexa was increased to five mg by mouth at bedtime included Lexapro, an antidepressant, 15 mg by mouth daily (started on 04/25/25) and Wellbutrin extended release (XL), an atypical antidepressant, 150 mg by mouth every morning (started on 04/27/25). Review of the Psychiatric Subsequent Assessment note dated 06/23/25, two weeks after increasing the Zyprexa to 5mg, revealed Resident #9 was seen for an exacerbation of chronic problems that included excessive worry and agitation. There was no indication of symptoms related to psychosis. Review of the care plan last updated 11/11/25 revealed Resident #9 used psychotropic medications related to major depressive disorder. Interventions included administration of medications per orders, consideration of a gradual dose reduction when clinically appropriate at least quarterly, monitoring Resident #9 for effectiveness or side effects of medications every shift, and monitoring for adverse reactions, such as unsteady gait, tardive dyskinesia, shuffling gait, rigid muscles, shaking, worsening depression, suicidal ideation, or unusual behaviors. Review of the Abnormal Involuntary Movement Scale (AIMS) assessments revealed Resident #9 only had two completed AIMS assessments, dated 04/06/25 and 11/12/25. Review of the psychiatric assessment visit notes from visits dated 06/09/25, 06/23/25, 07/14/25, 09/15/25, 10/13/25, and 11/10/25 revealed no clinical evaluation or indication of schizophrenia, bipolar disorder, or acute manic episodes. Furthermore, none of the notes reviewed indicated failed antidepressant therapy trials. Interview on 12/04/25 at 10:57 A.M. with Psychiatric Nurse Practitioner (NP) #939 revealed Resident #9 was placed on the antipsychotic medication prior to NP #939 taking over the case and that there were no supporting diagnoses for the medication. Further interview with NP #939 confirmed Resident #9's diagnoses did not include schizophrenia, bipolar disorder, or symptoms related to mania. During the interview, NP #039 denied knowledge of failed attempts to control depression with an antidepressant and expressed that, according to review of past visit notes, it had appeared that Resident #9 was placed on the Zyprexa for agitation and that an antipsychotic should not be used to treat behaviors in residents with dementia. Interview on 12/04/25 at 11:35 A.M. with the Director of Nursing (DON) confirmed Resident #9 had not had quarterly AIMS assessments completed prior to 04/06/25 or between 04/06/25 and 11/12/25 and (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #9 had no diagnoses of schizophrenia or bipolar disorder. Review of the policy titled Psychotropic Drug Usage last revised June 2024 revealed psychotropic drugs were to be used only as clinically indicated and that when administered for approved indication, AIMS assessments were to be completed upon initiation, quarterly, and with significant variation in status. Review of the United States (U.S.) Food and Drug Administration (FDA) latest approved labeling information, last updated January 2025, found at https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/020592s077,021086s050,021253s047s066lbl.pd revealed the approved uses for Zyprexa included the treatment of schizophrenia, acute treatment of manic or mixed bipolar I disorder, or in combination with fluoxetine (Symbyax) to treat depressive episodes caused by bipolar I disorder or the treatment of resistant depression where the recipient previously failed at least two separate trials of antidepressants. Review of the FDA approved use of Zyprexa further revealed use of the drug in elderly people with dementia-related psychosis have increased mortality rates and Zyprexa was not approved for the treatment of dementia-related psychosis.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review, interview and policy review the facility failed to ensure comprehensive care plans were completed for one resident (Resident #63) of six reviewed for care plans. The facility census was 65.Findings include:Review of the medical record for Resident #63 revealed an admission date of 09/12/25. Diagnoses included but were not limited to dementia with psychotic disturbance, unspecified protein-calorie malnutrition, paranoid schizophrenic, anxiety disorder, delusional disorders and paranoid personality disorder.Review of the 09/25/25 admission Minimum Data Set (MDS) 3.0 for Resident #63 revealed a Brief Interview of Mental Status (BIMs) score of 13. Review of Activities of Daily Living (ADLs) revealed Resident #63 was noted to require set up for eating and bathing, supervision for toileting, dressing, personal hygiene and transfers.Review of the comprehensive care plan dated 10/15/25 for Resident #63 revealed no evidence of a nutrition care plan or an activities of daily living (ADL) care plan. Phone interview on 12/03/25 at 2:00 P.M. with Registered Dietitian (RD) #834 revealed she does not complete resident care plans and stated facility staff complete the care plans. Interview on 12/03/25 at 2:46 P.M. with MDS Registered Nurse (RN) #939 revealed she thought the RD completed nutrition care plans and was unaware the nutrition and ADL care plans were not completed. Review of the 06/2019 facility policy called; Care Planning revealed it is the policy of the facility that the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident. A comprehensive care plan is developed within seven days of completion of the comprehensive assessment.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on record review, interviews, and facility bathing policy, the facility failed to ensure bathing was provided and documented for one independent resident (Resident #61) of three reviewed for bathing. The facility census was 65.Findings include:Review of the medical record for Resident #61 revealed an admission date of 06/13/24. Diagnoses included but were not limited to paranoid schizophrenia, vascular dementia, schizoaffective bipolar type disorder, adult failure to thrive, unspecified protein-calorie malnutrition, and Alzheimer's dementia. Under the shower task, Resident #61 was scheduled to have Tuesday and Saturday night bathing.Review of the 10/30/25 quarterly Minimum Data Set (MDS) 3.0 for Resident #61 revealed a Brief Interview of Mental Status (BIMs) of nine which indicated moderate cognitive impairment. Review of the Activities of Daily Living (ADLs) for Resident #61 revealed resident was independent for bathing.Review of the care plan for Resident #61 revealed it was last reviewed on 10/31/25. Resident #16 was noted to have an ADL self-care performance deficit related to dementia, schizophrenia, Alzheimer's dementia and failure to thrive. Resident #61 was noted to have a phobia of water and requested no showers. Interventions included offer resident non-water hygiene products to wash with. Provide a sponge bath when a full bath or shower cannot be tolerated.Review of the facility shower schedule revealed only one day a week for bathing for Resident #61 and listed bathing on Thursday but did not specify day or night shift.Review of the completed shower sheets for Resident #61 from September through November 2025 revealed completed shower sheets for 09/01/25, refusal noted on 09/04/25, 09/08/25, 09/11/25, 09/16/25, 09/18/25, 09/25/25, 10/02/25, a refusal noted on 10/06/25, a refusal noted on 10/09/25, a refusal noted on 10/16/25, 10/20/25, 10/23/25, 10/27/25, 10/30/25, 11/03/25, 11/06/25, 11/10/25, 11/13/25, 11/17/25, and 11/20/25. Out of 26 bathing opportunities, bathing was only offered 21 times. Observation on 12/01/25 at 3:04 P.M. revealed Resident #61 sitting in the common area and appeared to have greasy hair that did not appear to have been recently combed. Interview on 12/03/25 at 10:19 A.M. with Licensed Practical Nurse (LPN) #817 confirmed residents are supposed to get shower twice a week and as needed and staff are supposed to complete a shower sheet each time. Interview on 12/03/25 at 3:25 P.M. with Assistant Director of Nursing (ADON) #822 confirmed staff are to provide at least two showers weekly. Staff are to complete the shower sheet and document under the bathing task each time. If bathing is refused, it is to be documented on the shower sheet, and the nurse is to document the refusal in the medical record. ADON #822 confirmed the post shower schedule for the memory care unit only listed one day a week for each resident and confirmed the facility was unable to provide evidence of all of the schedule bathing opportunities for Resident #61 for the past three months. Interview on 12/04/25 at 8:20 A.M. with the Director of Nursing (DON) confirmed the facility did not have a specific policy for bathing and confirmed it is the facility's policy to provide at least two showers per week. Review of the 03/2019 revised facility policy called; Activities of Daily Living- Highest Level of Functioning revealed it is the policy of this facility to provide care and services to ensure that a resident is able to maintain their ability to self-perform their activities of daily living at their level of functioning prior to facility admission, unless circumstances of the individual's clinical condition demonstrate that diminishment in ability was unavoidable. The facility is responsible to provide necessary care to all residents who are unable to carry out activities of daily living on their own to ensure they maintain proper nutrition, grooming and hygiene.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on record review, interviews, and facility bathing policy, the facility failed to ensure bathing was provided and documented for two dependent residents (Residents #14 and #63) of three reviewed for bathing. The facility census was 65.Findings include:1.Review of the medical record for Resident #14 revealed an admission date of 08/26/23. Diagnoses included but were not limited to vascular dementia, altered mental status transient cerebral ischemic attack, anxiety disorder and unspecified protein-calorie malnutrition. Review of the shower task revealed showers were scheduled for Sunday and Wednesday night shift.Review of the 11/21/25 quarterly Minimum Data Set (MDS) 3.0 assessment for Resident #14 revealed a Brief Interview of Mental Status (BIMs) of three which indicated severe cognitive impairment. Resident #14 was noted to be dependent upon staff for bathing.Review of the care plan last for Resident #14 last reviewed on 11/26/25 revealed she required staff assistance with bathing.Observation on 12/01/25 at 11:52 A.M. revealed Resident #14 dressed and sitting with two other residents in the common area watching TV. Resident #14 was noted to be pleasantly confused, had stains on her clothes and her hair appeared to be greasy.Review of the undated facility memory care unit shower schedule revealed Resident #14 was scheduled for Thursday and did not list a second day of the week or state which shift bathing was supposed to occur.Review of the completed shower sheets for Resident #14 from September through November 2025 revealed completed shower sheets for 09/11/25, 09/15/25, 09/18/25, 09/25/25, 10/14/25, 10/17/25, 10/21/25, 10/24/24, 10/27/25, 10/30/25, 11/10/25, 11/14/25, 11/17/25, 11/20/25, 11/27/25, and 11/28/25. Out of 26 bathing opportunities, bathing was offered 16 times.Interview on 12/03/25 at 9:50 A.M. with Certified Nurse Aide (CNA) #816 revealed Resident #14 received showers on day shift and does not usually refuse showers.Interview on 12/03/25 at 10:36 A.M. with CNA #818 revealed Resident #14 is pleasantly confused but does not usually refuse bathing. Resident #14 is a Thursday shower but was unsure of the second day of the week for showers and confirmed there was not a second shower day listed on the unit shower schedule.Interview on 12/03/25 at 3:25 P.M. with Assistant Director of Nursing (ADON) #822 confirmed staff are to provide at least two showers weekly. Staff are to complete the shower sheet and document under the bathing task each time. If bathing is refused, it is to be documented on the shower sheet, and the nurse is to document the refusal in the medical record. ADON #822 confirmed the post shower schedule for the memory care unit only listed one day a week for each resident and confirmed the facility was unable to provide evidence of all of the schedule bathing opportunities for Resident #14 for the past three months. Interview on 12/04/25 at 8:20 A.M. with the Director of Nursing (DON) confirmed the facility did not have a specific policy for bathing and confirmed it is the facility's policy to provide at least two showers per week. 2. Review of the medical record for Resident #63 revealed an admission date of 09/12/25. Diagnoses included but were not limited to dementia with psychotic disturbance, paranoid schizophrenia, and delusional disorders. Review of the bathing task for Resident #63 revealed no specified date or shift for bathing.Review of the care plan dated 10/15/25 for Resident #63 revealed no activities of daily living (ADL) care plan.Review of the facility memory care unit shower schedule revealed Monday as a shower day but did not last a second day of the week or which shift was to complete bathing for Resident #63.Review of the facility provided shower sheets for Resident #63 from September to December revealed shower sheets for 09/12/25, 09/18/25, 09/22/25, 09/25/25, 10/13/25, 10/20/25, 10/27/25, a refusal noted on 11/03/25, 11/04/25, 11/10/25, 11/24/25, and 12/01/25. Out of 22 bathing opportunities since admission, Resident #63 was noted to be offered bathing 12 times.Observation on 12/01/25 at 12:57 P.M. revealed Resident #63 walking on the unit with visibly dirty clothes and greasy hair that did not appear to have been combed.Interview on 12/02/25 at 12:32 P.M. with Registered Nurse (RN) #816 revealed showers are supposed to be twice a week for resident. RN #816 stated Resident #63 sometimes refuses bathing but will be charted on behaviors and will list shower refusal on the shower sheet and be documented in the medical (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record.Interview on 12/03/25 at 9:50 A.M with Certified Nurse Aide (CNA) #816 revealed Resident #63 will sometimes refuse showers but usually will comply when reapproached. Resident #63 frequently spills things on himself and usually requires to have his clothes changed multiple times a day but allows the staff to change him and be bathed. Interview on 12/03/25 at 10:19 A.M. with Licensed Practical Nurse (LPN) #817 confirmed residents are supposed to get shower twice a week and as needed and staff are supposed to complete a shower sheet each time. Interview on 12/03/25 at 3:25 P.M. with ADON #822 confirmed staff are to provide at least two showers weekly. Staff are to complete the shower sheet and document under the bathing task each time. If bathing is refused, it is to be documented on the shower sheet, and the nurse is to document the refusal in the medical record. ADON #822 confirmed the post shower schedule for the memory care unit only listed one day a week for each resident and confirmed the facility was unable to provide evidence of all of the schedule bathing opportunities for Resident #63 for the past three months. Interview on 12/04/25 at 8:20 A.M. with DON confirmed the facility did not have a specific policy for bathing and confirmed it is the facility's policy to provide at least two showers per week. Review of the 03/2019 revised facility policy called; Activities of Daily Living- Highest Level of Functioning revealed it is the policy of this facility to provide care and services to ensure that a resident is able to maintain their ability to self-perform their activities of daily living at their level of functioning prior to facility admission, unless circumstances of the individual's clinical condition demonstrate that diminishment in ability was unavoidable. The facility is responsible to provide necessary care to all residents who are unable to carry out activities of daily living on their own to ensure they maintain proper nutrition, grooming and hygiene. This deficiency is an example of continued non-compliance from the survey dated 11/19/25.

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Continuing Healthcare of Cuyahoga Falls	300 East Bath Road Cuyahoga Falls, OH 44223

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and review of the facility policy, the facility failed to ensure pharmacy recommendations were addressed in a timely manner. This affected two residents (#6 and #10) of five residents reviewed for unnecessary medications. Facility census was 65.Findings include: 1.Review of Resident #6's medical record revealed an admission date of 02/17/23 and diagnoses including chronic obstructive pulmonary disease (COPD), chronic kidney disease, depression, anemia, anxiety, heart failure and hypertension. Resident #6 signed on hospice services as of 10/30/25. Review of Resident #6's significant change Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #6 was cognitively intact and reported frequent, moderate pain. Resident #6 received hospice services. Review of Resident #6's physician orders as of 12/03/25 revealed an order dated 07/21/25 for diclofenac sodium external gel 1% apply to knees topically every six hours as needed for pain. No dose was specified in the order. Review of a pharmacy recommendation dated 08/18/25 revealed Resident #6 had an order for diclofenac (Voltaren) gel. Please provide a dose. Suggested dosing was listed on the recommendation form. Interview on 12/03/25 at 5:28 P.M. with the Director of Nursing (DON) verified Resident #6's diclofenac gel did not have a dose listed per the pharmacy recommendation dated 08/18/25 and confirmed it should have indicated a dosage for use and was not addressed timely. 2. Review of the medical record for Resident #10 revealed an admission date of 09/05/25 with diagnoses including fracture of the right ileum (one of the three bones that form the pelvis), muscle weakness, abnormalities of gait and mobility, unspecified severe protein-calorie malnutrition, chronic obstructive pulmonary disease (COPD), venous insufficiency, major depressive disorder, anemia, neuropathy, and acute pain related to trauma. Review of the Modification of Quarterly Minimum Data Set (MDS) 3.0 assessment completed on 10/09/25 revealed Resident #10 had moderate cognitive impairment and mild depression. Further review of the MDS revealed Resident #10 had received pain medication on an as-needed basis and received antipsychotic, antianxiety, and antidepressant medications. Review of the orders revealed an order dated 09/05/25 for diclofenac sodium external gel one percent (%) to be applied topically to the lower back of Resident #10 two times a day for pain. Further review of the order revealed the medication instructions did not contain and ordered amount to apply during medication administration and no order modifications had been made since the original order date of 09/05/25. Review of the documents titled Pharmacy Recommendations to Nursing Staff dated 09/22/25, 10/16/25, and 11/20/25 revealed each recommendation contained the same verbiage from the consulting pharmacist to the facility staff, which stated, Resident has an order for: Diclofenac (Voltaren) gel. Please provide a dose. Please note suggested dosing: 1. For upper extremities: Apply 2 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	grams Q 9every) 6 hours - not to exceed 8 grams/day to any single joint 2. For lower extremities: Apply 4 grams Q 6 hours - not to exceed 16 grams/day to any single joint. Further review of the written pharmacy recommendations revealed there was no response from the facility on the document dated 09/22/25, a handwritten note stating, Apply to Lower Back with no date or signature on the document dated 10/16/25, and a handwritten note stating Apply to Low Back - Not an extremity - with no date or signature on the document dated 11/20/25. Interview on 12/03/25 at 4:47 P.M. with the Director of Nursing (DON) confirmed the pharmacist's recommendations included a request for the facility to add a dose to the Diclofenac gel order with the monthly medication regimen reviews completed on 09/22/25, 10/16/25, and 11/20/25. During the interview, the DON also confirmed no changes were made to the medication order and because the recommendation was labeled to the attention of the nursing staff, the recommendation was not forwarded to the physician or Nurse Practitioner for review or to act upon. Review of the policy titled Medication Regimen Review effective August 2020 revealed the prescriber would be notified of any changes needed to the resident's medication regimen, irregularities were to be reported to the DON, physician, or ordering provider, and all recommendations were to be acted upon or addressed and documented by the prescriber. Further review of the facility revealed recommendations that did not require physician intervention still required nursing staff to address and document that the recommendation(s) had been acted upon.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interview, the facility failed to ensure a medication error rate of less than 5%. A total of 28 medications were administered with two errors for a medication error rate of 7.14%. This finding affected two (Residents #11 and #49) of six residents observed for medication administration. Findings include:1. Review of Resident #11's medical record revealed the resident was admitted on [DATE] with diagnoses including alcohol abuse, depression and anxiety.Review of Resident #11's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment.Review of Resident #11's physician orders revealed an order dated 11/17/25 for Sertraline (Zoloft) antidepressant, give 75 milligrams (mg) by mouth in the morning for depression.Observation on 11/19/25 at 8:03 A.M. with Licensed Practical Nurse (LPN) #817 of Resident #11's medication administration revealed two medications were administered with one error. LPN #817 administered 25 mg of Sertraline antidepressant, and the physician ordered 75 mg.Interview on 11/19/25 at 1:15 P.M. with LPN #817 confirmed she administered the wrong dose of Zoloft antidepressant to Resident #11.2. Review of Resident #49's medical record revealed the resident was admitted on [DATE] and readmitted on [DATE] with diagnoses including alcohol abuse, muscle weakness and difficulty in walking.Review of Resident #49's admission MDS 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment.Review of Resident #49's physician orders revealed an order dated 10/17/25 for Thiamine oral capsule 100 mg by mouth one time a day for a supplement.Observation on 11/19/25 at 8:35 A.M. with LPN #821 of Resident #49's medication administration revealed six medications were administered; however, the physician ordered Thiamine was not administered.Review of Resident #49's medication administration records (MARS) and treatment administration records (TARS) from 11/01/25 to 11/20/25 revealed LPN #821 documented she administered the resident's Thiamine as ordered on 11/19/25.Interview on 11/19/25 at 8:37 A.M. with LPN #821 confirmed Resident #49's Thiamine was not administered as ordered.Interview on 11/20/25 at 10:26 A.M. with the Director of Nursing (DON) confirmed LPN #817 had documented she administered Resident #49's Thiamine as administered on 11/19/25 inaccurately. The DON confirmed the Thiamine was on another cart in the building.A total of 28 medications were administered with two errors for a medication error rate of 7.14%.Review of the Medication Administration policy revised 06/2019 revealed it was the policy of the facility that the facility would implement a Medication Management Program that incorporates systems with established goals to meet each resident's needs as well a regulatory requirement.This deficiency represents non-compliance investigated under Complaint Number 2673792.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure foods were provided per preference. This affected one resident (#42) of seven residents observed at meals and reviewed for nutrition. Facility census was 65.Findings include:Review of Resident #42's medical record revealed an admission date of 09/24/25 and diagnoses including heart failure, unspecified protein-calorie malnutrition, Wernicke's encephalopathy and alcohol abuse. Review of Resident #42's medical record as of 12/03/25 revealed a pnysician's order dated 09/24/25 for a regular diet with no lactose and double portions. Review of Resident #42's admission minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #42 was cognitively intact and was independent with eating. Review of a nutrition assessment dated [DATE] revealed Resident #42 was ordered a regular diet and ate independently. Review of nurses' notes from 09/24/25 through 12/02/25 did not mention food preferences including double portions at meals.Interview on 12/01/25 at 10:50 A.M. with Resident #42 revealed he was not getting double portions at meals and this started three days after he admitted to the facility in September 2025.Observation on 12/03/25 at 8:04 A.M. revealed Resident #42's tray was on a table in his room. The tray contained a coffee mug, grape juice, bowl of oatmeal, one hard-boiled egg and one piece of toast. The tray card on the tray stated Resident #42 was to receive a regular, lactose free diet with coffee and orange juice. No other diet requests were noted on the tray card. Observation and interview on 12/03/25 at 8:05 A.M. with Certified Nursing Assistant (CNA) #881 confirmed there was one hard-boiled egg and one slice of toast on Resident #42's tray and that did not constitute double portions at the breakfast meal. CNA #881 stated she was unaware Resident #42 was to receive double portions.Interview on 12/03/25 at 8:09 A.M. with the Director of Nursing (DON) revealed Resident #42 had wanted double portions at meals upon admission and was shown Resident #42's tray card during the interview. The DON confirmed the tray card did not reflect Resident #42's preference for double portions at meals and verified one hard-boiled egg and one slice of toast did not constitute double portions at the breakfast meal.Review of a diet list dated 12/03/25 revealed Resident #42 was on a regular diet, no lactose with double portions.

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F 0607 Level of Harm - Potential for minimal harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on record review and interview, the facility failed to implement their abuse prevention policy and procedure to ensure new staff were checked on the Nurse Aide Registry as required. This has the potential to affect all 65 residents in the facility.Findings include: Review of the personnel file for Certified Occupational Therapy Assistant (COTA) #836 revealed a start date of 11/17/25. There was no evidence of search results from the Nurse Aide Registry (NAR). Review of the personnel file for Dietary Manager #820 revealed a start dated of 11/11/25. There was no evidence of search results from the NAR.Review of the personnel file for Director of Nursing (DON) revealed a start date of 08/18/25. There was no evidence of search results from NAR.Review of the personnel file for Licensed Practical Nurse #803 revealed a start date of 09/16/25. There was no evidence of search results from NAR.Interview on 12/02/25 at 2:12 P.M. with DON verified the personnel records did not contain evidence of NARs for above staff. Review of the policy titled Abuse, Neglect, and Exploitation (ANE) Prohibition, revised 10/2024, revealed the facility screened potential employees for a history of abuse, neglect, or mistreatment of residents through licensure verifications and misconduct registry as required aby applicable state or federal regulation.

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F 0835 Level of Harm - Potential for minimal harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on record review, interview, and facility policy review, the facility failed to complete employee physical screenings prior to employment. This had the potential to affect all 65 residents at the facility. Findings include:Review of the personnel file for Director of Nursing revealed a hire date of 08/18/25. The physical was not signed or dated by appropriate personnel.Review of the personnel file for Licensed Practical Nurse #803 revealed a hired date of 09/16/25. The physical was not signed or dated by appropriate personnel.Review of the personnel file for CNA #816 revealed a hire date of 09/19/25. The physical was not signed or dated by appropriate personnel. Review of the personnel file for Certified Nursing Assistant (CNA) #912 revealed a hire date of 11/11/25. The physical was not signed or dated by appropriate personnel.Review of the personnel file for Certified Occupational Therapy Assistant revealed a hire date of 11/11/25. The physical was not signed or dated by appropriate personnel.Review of the personnel file for Dietary Manager #820 revealed a hire date of 11/11/25. The physical was not signed or dated by appropriate personnel.Interview on 12/03/25 at 8;43 A.M. with Human Resource Director (HRD) #823 revealed she was on medical leave from 09/12/25 through 11/19/25. She was only in the facility Monday, Wednesday and Fridays now. HRD #823 stated physicals were done at orientation where a facility nurse obtained height, weight, the employee filled out the form and the form was reviewed and signed by the Certified Nurse Practitioner (CNP) during her visits once a week. HRD #823 had not met the CNP, a change that was made while she was off. HRD #823 verified the six physicals were not signed or dated by appropriate personnel.Review of the facility policy titled Employee Health Screening, last revised June 2025, revealed all employees must complete a pre-employment physical examination. The physical/health screening must be completed by a licensed physician, physician assistant, or APRN or a licensed nurse performing a state-accepted health screening under appropriate supervision or facility policy. The exam must include date of examination, name and credentials of the healthcare professional completing the review.

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, facility policy and assessment review, the facility failed to ensure the facility assessment was comprehensive as required. This had the potential to affect all residents residing at the facility. The facility census was 65.Findings include:Review of the facility assessment dated [DATE] revealed under the acuity section different examples of care areas were listed but was not differentiated by units. Under the services provided sections various general care areas were listed but were not differentiated by units. Review of the Full Time Employees (FTEs)/Contractors required section revealed seven FTEs for Registered Nurses, 16 FTEs for Licensed Vocational Nurses (LVNs) and 33 FTEs for Certified Nursing Aides (CNAs). It did not specify how many FTEs per shift or how many of each staff type per unit. Under the staff considerations by unit section, it listed day shift is typically staff with charge nurse and a CNA coverage. Staffing levels may vary based on patient acuity, census and staffing variables. Night Shift is typically staffed with charge nurse and CNA coverage. Staffing levels may vary based on patient acuity, census and staffing variables. Interview on 12/04/25 at 11:07 A.M. with the Director of Nursing (DON) confirmed the facility assessment was not specific to par staffing levels and did not differentiate between the different units and levels of care as required.