

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: 365834	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/10/2025
NAME OF PROVIDER OR SUPPLIER Majestic Care of Kent		STREET ADDRESS, CITY, STATE, ZIP CODE 1290 Fairchild Avenue Kent, OH 44240	
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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of personnel files, review of a self-reported incident (SRI), review of the facility's investigation and review of the facility policy, the facility failed to implement its abuse policy relative to screening staff against the Nurse Aide Registry (NAR) prior to employment as well as timely reporting, thorough investigations and effective education of staff regarding abuse. This affected three personnel files for [NAME] #569, Certified Nursing Assistant (CNA) #561 and Activity Assistant (AA) #585 out of nine files reviewed with the potential to affect all 55 resident in the facility. 1. Review of personnel files on 08/28/25 at 9:21 A.M. and 3:34 P.M. with the Administrator and Human Resources (HR) #590 revealed the following areas of concern: a. Review of CNA #561's personnel file revealed a hire date of 08/22/24. There was no check against the NAR to rule out any findings of abuse and neglect until 03/06/25. b. Review of [NAME] #569's personnel file revealed a hire date of 05/28/25. There was no evidence [NAME] #569 was checked against the NAR to rule out any findings of abuse and neglect. c. Review of AA #585's personnel file revealed a hire date of 07/16/25. There was no evidence AA #585 was checked against the NAR to rule out any findings of abuse and neglect. Interview on 08/28/25 at 3:55 P.M. with the Administrator verified staff were to be checked against the NAR prior to working with residents to rule out any findings of abuse and neglect. Review of the facility policy, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation, revised 06/05/25 and effective 07/01/25 revealed the facility would do the following prior to hiring a new employee: a) check the Nurse Aide Registry (and attempt to check other state registries if the individual is known to have worked in another state) for all potential new employees (licensed and unlicensed) and new volunteers to determine if there is a finding of abuse, neglect or misappropriation of property against the individual prior to the use of that individual. 2. Review of Resident #49's medical record revealed an admission date of 03/01/24 and diagnoses including Alzheimer's disease, dysphagia, constipation, generalized anxiety disorder, vascular dementia with behavioral disturbance, psychotic disorder and mood affective disorder. Resident #49 had a legal guardian and was receiving hospice services. Review of Resident #49's quarterly minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #49 had cognitive impairment, displayed physical and verbal behaviors one to three days in the look-back period and was dependent for upper body and lower body dressing. Review of Resident #23's medical record revealed an admission date of 08/11/22 and diagnoses including Asperger's syndrome, morbid obesity, depression, type two diabetes and insomnia. Resident #23 was his own responsible party. Review of Resident #23's quarterly MDS 3.0 assessment dated [DATE] revealed Resident #23 was cognitively intact and did not display behaviors. Resident #23 was dependent for dressing, personal hygiene and dressing and required partial/moderate assistance for rolling. Review of a SRI dated 07/27/25 and submitted to the State Agency (SA) at 4:23 P.M. revealed an allegation of staff to resident neglect involving Certified Nursing Assistant (CNA) #555, Resident #23 and Resident #49. Licensed Practical Nurse (LPN) #536 informed Unit Manager (UM)/LPN #532 that CNA #561 expressed concern that CNA #555 who was working with her had yelled at and shook Resident #49 while dressing him in her presence. CNA #561 also reported that CNA #555 went into Resident #23's room and argued with him. The allegation was not reported to (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	allegations to the Administrator and to Department of Health (DOH) in accordance with the procedures in this policy. [The facility would ensure] all care team members would report all incidents and allegations of abuse, neglect, mistreatment, exploitation and misappropriation of resident/patient property, as well as notifying the Administrator, Director of Nursing, or charge nurse immediately upon identification of any new injuries. If a care team member is accused or suspected, the facility should immediately remove the care team member from the facility and schedule pending the outcome of the investigation. All incidents and allegations of abuse, neglect, exploitation, mistreatment and misappropriation of resident/patient property and all injuries of unknown source must be reported immediately to the Administrator/designee and they should be notified in person, via telephone, text message or phone call. Once the Administrator and the Department of Health (DOH) are notified, an investigation of the alleged violation will be conducted. The person investigating the incident should generally take the following actions: Interview the resident/patient, the accused, and all witnesses. Witnesses generally include anyone who: witnessed or heard the incident, came in close contact with the resident the day of the incident (including the other patients/residents, family members) and employees who worked closely with the accused employees and/or alleged victim the day of the incident. If there are no direct witnesses, the interviews may be expanded. Consider interviews with all care team members on the shift or the unit as well as other residents/patients on the unit. If the allegation involves abuse/neglect interview other residents to determine if they may have been affected by the accused care team member. If the accused is a care team member, employment records are reviewed. If the facility suspects that a crime has been committed, it will report that suspicion to law enforcement. If the resident has serious bodily injury, law enforcement must be notified within two hours; without serious bodily injury, law enforcement must be notified within 24 hours. Facility will educate its care team members upon hire and annually thereafter regarding the facility's policy concerning abuse, neglect, exploitation and misappropriation of resident's property and training will include but not be limited to how to report knowledge related to allegations without fear of reprisal. Ensure resident and other residents are protected throughout the investigation.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and review of the facility policy, the facility failed to ensure foods were labeled, dated and not retained when expired. This affected 53 residents receiving meals from the kitchen as Residents #2 and #50 were ordered nothing-by-mouth. Facility census was 55. Findings include: Observation on 09/02/25 starting at 10:40 A.M. with Dietary Manager (DM) #552 revealed in the dry store room, there was an unlabeled and undated container full of dry brown rice and two expired bags of bread crumbs with an expiration date of 08/01/25. In the walk-in cooler, there was a bottle of raspberry decorative sauce dated 01/27/25. Interviews with DM #552 verified the above findings at the time of observation. DM #552 stated she was to check food dates daily and her staff were to check dates when they prepared food items. Review of a list of resident diets revealed Resident #2 and #50 received no food by mouth. Review of the policy, Labeling and Dating Guidelines, dated 01/02/24, revealed all opened and leftover items will be labeled with the date of opening/date stored and a discard/use by date. The date the product must be consumed or discarded by may not exceed the manufacturer's use by date. These are guidelines and should not be used in place of good judgement.		

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F 0843 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. Based on record review and interview, the facility failed to have a written transfer agreement with one or more hospitals. This had the potential to affect all 55 residents residing in the facility. Findings include: Review of the hospital-nursing facility transfer agreement dated 12/31/24 revealed the hospital had not signed the agreement, only the facility agent. Interview on 09/03/25 at 8:22 A.M. with the Administrator revealed she was unable to find a signed transfer agreement with a hospital. She stated she was only able to locate the transfer agreement dated 12/31/24 and it was not signed by the hospital.		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review, facility policy and procedure review and interview, the facility failed to ensure their Quality Assurance and Performance Improvement (QAPI) committee identified and followed through on staff education. This had the potential to affect all 55 residents in the facility. Findings include: Findings include: Review of the facility QAPI minutes and Performance Improvement Plan (PIP) documentation revealed the following plans without continued corrective action, evidence the plan was revised when necessary or changed once identified to be ineffective: Review of the QAPI meeting dated 03/12/25 revealed facility staff met to review concerns for January and February 2025. Online education began in February 2025 with only a 14% staff participation rate. The plan was to provide training, post signs in the breakroom, review during monthly in-services and to have a gift card giveaway. The minutes did not specify what the online education was. Review of the QAPI meeting dated 06/02/25 revealed facility staff met to review concerns for March and April 2025. Online education compliance revealed March 2025 had 17% of staff participation and April 2025 revealed 19% staff participation. The plan was again to post signs in the breakroom, review during monthly in-services and to have a gift card giveaway. The minutes did not specify what the online education was. Review of the QAPI meeting dated 07/17/25 revealed facility staff met to review concerns for May and June 2025. Online education and staff training were not reviewed. Review of the QAPI meeting dated 08/29/25, after concerns of lack of staff education from the survey team, revealed online education was going poorly. During the current annual survey, deficiencies were cited regarding staff education. The minutes did not specify what the online education was. Interview on 09/04/25 at 12:10 P.M. with Regional Nurse Consultant #598 verified there was no QAPI meeting in January 2025. She also verified the facility's Administrator was responsible for implementing and overseeing auditing as well as quality assurance. Regional Nurse Consultant #598 verified the facility had not followed the QAPI plan to ensure staff training improved. Review of the facility policy titled, QAPI Plan, dated 01/02/24, revealed the Quality Assessment and Assurance (QAA) Committee would determine what performance indicators would be monitored and schedule the frequency of monitoring, identify and respond to quality deficiencies throughout the facility, develop and implement corrective action plans to ensure goals and targets were achieved and monitor the effectiveness of its performance improvement activities to ensure improvements were sustained.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on personnel file review, interview and review of the facility policy, the facility failed to ensure staff had tuberculosis (TB) testing prior to working. This affected two staff (Licensed Practical Nurse (LPN) #536 and Certified Nursing Assistant (CNA) #561) of nine staff reviewed during the annual survey with the potential to affect all 55 residents. Findings include: Review of LPN #536's personnel file revealed a hire date of 05/05/25. Further review of the personnel file revealed no evidence TB testing was completed prior to or upon employment. Review of CNA #561's personnel file revealed a hire date of 08/22/24. Further review of the personnel file revealed no evidence TB testing was completed prior to or upon employment. Interview on 09/03/25 at 2:46 P.M. with Regional Human Resources (RHR) #600 and Human Resources (HR) #590 verified they could not locate initial TB testing for LPN #536 or CNA #561. RHR #600 stated a two-step TB test was done upon hire for all new employees. Review of the facility policy, Tuberculosis (TB) Prevention and Control, dated 01/02/24 revealed residents and staff are tested for latent TB infection and screened for TB disease. Review of the facility's TB risk assessment dated [DATE] revealed the facility has a TB screening program for nurses, administrators, janitorial staff, maintenance or engineering staff, transportation staff, dietary staff, physical therapists, receptionist and trainees/volunteers. Baseline skin testing was performed with two-step tuberculin skin test (TST) for health-care workers upon employment.		

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on personnel file review and interview the facility failed to ensure Certified Nursing Assistants (CNAs) had 12 hours of training annually as required. This affected one CNA (#561) of two CNA files reviewed with the potential to affect all 55 residents. Findings include: Review of CNA #561's personnel file revealed a date of hire of 08/22/24. Further review of the file revealed no evidence of training hours. Interview on 09/03/25 at 2:46 P.M. with Regional Human Resources (RHR) #600 and Human Resources (HR) #590 verified they could not locate any evidence of training hours for CNA #561. RHR #600 stated for CNAs, they aimed for at least 12 hours annually for training.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview and facility policy review, the facility failed to maintain resident rooms and bathrooms in a safe and sanitary condition. This affected four residents (Resident #28, #31, #34, and #44) of 55 residents living in the facility. The facility census was 55. Findings include: Interview and observation on 09/02/2025 at 4:41 P.M. with Certified Nursing Assistant (CNA) #555 of Resident #31 room revealed splatters of food on all four walls and the ceiling of room and outlet by bed was unattached from wall with the wires hanging out. Observation on 09/03/25 between 2:47 P.M. through 3:00 P.M. of multiple resident rooms with Housekeeping Supervisor #513 revealed the following: Resident #31 walls and ceiling were dirty with various food and liquid debris from resident throwing his food. Outlet was being fixed by maintenance at this time. Housekeeping Supervisor #513 revealed Resident #31 throws food at the wall and will put feces on the wall. Staff was supposed to clean daily but confirmed staff had not been wiping walls thoroughly. Resident #34 and Resident #44 ceiling had multiple brown splatters, and the privacy curtain ceiling track was partially missing with no privacy curtain. Resident #44 said the stains on the ceiling have been there since he moved into the room. The floorboard was missing to the right of the air-conditioning unit. The bathroom smelled of urine, the rim around the toilet was brown and the floor was sticky. Resident #34 pillow was stained brown and had no pillow case on it. Resident #28 bathroom tile was heavily stained brown due to the resident peeing on the floor and the room smelled of urine. There was a toilet safety rail above toilet with one piece on the right leg missing, causing railing to be unsteady. Interview on 09/02/25 at 3:00 P.M. with Housekeeping Supervisor #513 revealed he puts request in for items to be fixed and they are not approved. Housekeeping Supervisor #513 revealed he feels that request fall on deaf ears. Surveyor requested the service request but they were not provided. Interview and observation on 09/03/25 at 4:20 P.M. with Regional Director of Nurse Consultants #599 of above rooms and confirmed observations. Review of facilities policy Safe & Homelike Environment dated 01/02/24 revealed Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment.		

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. Based on record review and interview, the facility failed to ensure authorizations were witnessed for resident funds. This affected one resident (#42) of five residents reviewed for resident funds. Facility census was 55. Findings include: Review of Resident #42's medical record revealed an admission date of 07/19/22 and diagnoses including depression, insomnia, auditory hallucinations, delusional disorders, and psoriasis. Further review of the record revealed Resident #42 had a power of attorney (POA). Review of financial records for Resident #42 revealed an authorization for resident funds signed by the POA on 05/05/25. The authorization lacked any witness signatures on the form. Interview on 09/03/25 at 8:45 A.M. with Business Office Manager (BOM) #523 verified Resident #42 did not have his resident funds authorization witnessed as required. BOM #523 reported the facility did not have a policy regarding resident funds to provide for review at the time of the interview.		

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure final disbursement of a deceased resident's funds was completed in 30 days as required. This affected one resident (#64) of five residents reviewed for resident funds. Facility census was 55. Findings include: Review of Resident #64's closed medical record revealed an admission date of [DATE] and diagnoses including personality disorder, breast cancer, insomnia and mild cognitive impairment. Further review of the record revealed Resident #64 expired in the facility on [DATE]. Review of the financial records for Resident #64 revealed she expired on [DATE]. The resident statement indicated the balance of \$75.77 was issued as a check on [DATE]. During an interview on [DATE] at 8:45 A.M. Business Office Manager (BOM) #523 was informed that Resident #64's final disbursement exceeded the 30-day limit and she did not disagree. BOM #523 stated the receptionist and not herself did the disbursement for Resident #64. BOM #523 also reported the facility did not have a policy regarding resident funds to provide for review at the time of the interview.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of a self-reported incident (SRI), review of the facility's investigation and review of the facility policy, the facility failed to report allegations of abuse and neglect immediately as required. This affected two residents (#23 and #49) of three residents reviewed for abuse and neglect. Facility census was 55. Findings include: Review of Resident #49's medical record revealed an admission date of 03/01/24 and diagnoses including Alzheimer's disease, dysphagia, constipation, generalized anxiety disorder, vascular dementia with behavioral disturbance, psychotic disorder and mood affective disorder. Resident #49 had a legal guardian and was receiving hospice services. Review of Resident #49's quarterly minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #49 had cognitive impairment, displayed physical and verbal behaviors one to three days in the look-back period and was dependent for upper body and lower body dressing. Review of Resident #23's medical record revealed an admission date of 08/11/22 and diagnoses including Asperger's syndrome, morbid obesity, depression, type two diabetes and insomnia. Resident #23 was his own responsible party. Review of Resident #23's quarterly MDS 3.0 assessment dated [DATE] revealed Resident #23 was cognitively intact and did not display behaviors. Resident #23 was dependent for dressing, personal hygiene and dressing and required partial/moderate assistance for rolling. Review of a SRI dated 07/27/25 and submitted to the State Agency (SA) at 4:23 P.M. revealed an allegation of staff to resident neglect involving Certified Nursing Assistant (CNA) #555, Resident #23 and Resident #49. Licensed Practical Nurse (LPN) #536 informed the unit manager, UM/LPN #532, that CNA #561 expressed concern that CNA #555 who was working with her had yelled at and shook Resident #49 while dressing him in her presence. CNA #561 also reported that CNA #555 went into Resident #23's room and argued with him. The allegation was not reported to another agency. The facility determined the allegation of neglect to be unsubstantiated as Resident #23 refuted the allegation of verbal abuse and disputed information from CNA #561 could not be verified. Review of a timeline included in the facility's SRI investigation revealed on 07/27/25 (time not given), LPN #536 contacted UM/LPN #532 to report an allegation of abuse that was reported to her by CNA #561. CNA #561 reported that CNA #555 shook Resident #49 and yelled at him while they were dressing the resident (time not given). CNA #561 reported that CNA #555 had yelled out in a mocking manner saying okay, okay, okay which is what Resident #49 was known for repeating as he had limited verbalization due to his Alzheimer's diagnosis. It was reported that both CNAs then went to Resident #23's room (time not given) to assist with care. UM/LPN #532 instructed LPN #536 to ask CNA #555 to leave immediately (time not given) then go into Resident #23's room to ask about the reported allegation. Resident #23 denied concerns with staff, denied any CNA yelling or arguing with him and indicated he felt safe. UM/LPN #532 instructed LPN #536 to complete pain assessments on Resident #23 and Resident #49 and to complete skin assessments on all residents on the 300 and 400 halls. Resident #49's skin assessment was negative. UM/LPN #532 notified the Director of Nursing Services (DNS) and Regional Director of Operations (RDO) of the allegation, an SRI was initiated and an investigation began. Continued review of the facility's timeline revealed on 07/28/25, UM/LPN #532 assessed Resident #23 and Resident #49 who were within normal limits. Social Service Director (SSD) #559 observed and interviewed residents on the 300 and 400 halls with no findings. Continued review of the facility's timeline revealed on 07/29/25, Resident #23 had a care conference and did not voice any concerns or issues. A follow-up interview completed by the Administrator with CNA #555 revealed she was blindsided by the allegations as she had been a CNA at the facility for 14 years. CNA #555 stated she only touched Resident #49's shoulders when putting his shirt on and may have said okay, okay, okay but not in a mocking way but to repeat as that is how Resident #49 communicated. CNA #555 felt the allegations were false and may have been ignited the day before (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	because she had to repeatedly ask where the other CNA [#561] was during that shift. SSD #559 met with Resident #23 who was resting. SSD #559 met with Resident #23 again on 07/30/25 who was resting and smiled when he asked how he was feeling. Review of an undated witness statement authored by CNA #561 revealed it was directed towards the facility's previous Human Resource Director (HRD), UM/LPN #532 and the DNS and revealed the following information: I am writing to formally report a situation that I believe violated workplace policies and may have impacted my sense of safety and professionalism on the job. On 07/27/25 (no time given) I witnessed my co-worker [CNA #555] yell and shake a dementia patient [Resident #49] as we were dressing him. Then (no time given) the next patient [Resident #23] [CNA #555] argued with and I stepped in to diffuse the situation. The coworker cooled down but I reported this to two different nurses, UM/LPN #532 and the DNS. I believe it is important to bring this forward in the spirit of maintaining a respectful and accountable but mostly safe workplace. I am willing to cooperate with any investigation or discussion necessary. Please confirm receipt of this message and let me know the next steps. Review of a witness statement dated 07/27/25 and authored by CNA #555 revealed the following information: Today I help my co-worker with Resident #49 (no time given). Everything went good, she put his pants on and I put his shirt on and got him up in his chair. Additional writing on this statement dated 07/29/25 and signed by the Administrator revealed the following information: I knew the other CNA and did not expect anything. I don't know why she would make accusations. I have spent 14 years working at the facility. There was another accusation in the past made by the resident (not specified) a few months ago. I put his [Resident #49's] shirt on. I did not shake him. I may have said 'okay, okay,' but not to mock him - that's just how he communicates. I have never had a problem with the other CNA. I spent much of the day asking where the CNA was and the nurse (not specified) would say no. And I stated, 'I haven't either.' I don't know, I have worked here a long time and would never abuse a resident. I don't do this job for the Administrator or the DNS, I do it for the person in the bed. Review of a witness statement dated 07/27/25 and authored by Registered Nurse (RN) #518 revealed the following information: I was approached by CNA #561 (time not given) and she told me that she was in the room with CNA #555 changing Resident #49. She said CNA #555 was frustrated and shook Resident #49. She said she is about to be a nurse and that she would have to report it. Review of a witness statement dated 07/27/25 and authored by LPN #536 revealed the following information: CNA #561 came to me while I was walking down the hallway (time not given). CNA #561 stated while her and CNA #555 were in Resident #49's room she witnessed CNA #555 put her hands on Resident #49's shoulders and shake him, mocking him, saying 'okay, okay, okay.' I would like to add that I feel like CNA #561 was upset she was told by this nurse that she was working the 300 hall and the other CNA was working 400 hall by herself. I went in to speak to Resident #23 who stated nothing happened other than CNA #444 was moody and upset because she did not have any linen to do his bed bath. Additional writing present on LPN #536's statement that lacked a date and an author revealed that RN #518 reported to LPN #536 that something happened with CNA #555 between 9:30 A.M. and 10:00 A.M. which was late reporting and CNA #555 did an amazing job and never has issues. Review of a witness statement dated 07/27/25 and authored by LPN #578 denied witnessing abuse of any sort on 07/27/25 or any other days worked previously. Review of a witness statement dated 07/29/25 and authored by SSD #559 revealed she spoke with Resident #23 who was resting in bed and was alert and oriented times three. Resident #23 told SSD #559 that CNA #555 did not verbally abuse him and asked who the other CNA was that had come in and told him another resident had had an incident with CNA #555. Resident #23 stated he did not want to be put into this situation and stated he felt safe at the facility. Review of CNA #555's time punch detail revealed she worked on 07/27/25 from 6:56 A.M. to 3:34 P.M. The next date CNA #555 worked was on 08/05/25. Interview on 08/27/25 at 1:53 P.M. with Resident #23 revealed there was a CNA (not named) that was verbally abusive to him about four months ago and who had a snarky attitude. The CNA would make him wait, then not do what he requested. Resident #23 reported he had not seen the CNA in a while. Observation (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 08/28/25 at 12:42 P.M. revealed UM/LPN #532 was interacting with Resident #49 who was seated in a Broda chair on the secured unit. The surveyor asked Resident #49 how lunch was and Resident #49 put his head down and did not respond. Resident #49 was not interviewable due to cognition. Interview on 08/28/25 at 1:45 P.M. with RN #518 revealed on 07/27/25, she was working in the front of the facility on the 200 hall and CNA #555, CNA #561 and LPN #536 were in the back of the facility. Around 2:00 P.M. RN #518 was on her lunch and CNA #561 approached her while she was in her car. CNA #561 stated she thought she had to report something as CNA #555 was in a room with her and grabbed Resident #49 and shook him. RN #518 stated she told CNA #561, 'yes, you need to report that. You need to tell your charge nurse then contact the previous Administrator and if not the DNS.' RN #518 stated LPN #536 had called a member of management staff at some point and they were gathering statements from anyone CNA #555 and CNA #561 spoke to. When asked if she reported the allegation, RN #518 stated she did not tell anyone about the allegation as CNA #561 and LPN #536 were doing that. RN #518 stated CNA #561 was also telling a resident, Resident #11, about the incident and Resident #11 also told CNA #561 she had to report the allegation. Interview on 08/28/25 at 2:00 P.M. with CNA #573 revealed on 07/27/25, she was working in the front of the facility and recalled CNA #561 said CNA #555 said harsh words to an unknown resident. Around 3:00 P.M. CNA #561 appeared shook and came to her, telling her she reported the allegation to LPN #536 and RN #518 but did not report it right away. CNA #573 stated CNA #561 did not divulge what time the incident occurred at. When asked if she reported the allegation, CNA #573 stated she did not report this to anyone as CNA #561 did what she was supposed to do. CNA #573 also stated CNA #555 did not go home right away on 07/27/25 but should have and this was because the allegation was not reported as it was happening. CNA #573 reported she never was asked to write a statement regarding the allegation even as she was working the date and shift the allegation occurred within. Interview on 08/28/25 at 2:56 P.M. with LPN #536 revealed she worked on 07/27/25 in the back of the facility. Around 2:30 P.M. to 3:00 P.M. she went outside to take a smoke break and RN #518 told her CNA #561 was going to tell her that CNA #555 did something to Resident #49. LPN #536 stated she asked RN #518 what was she talking about and RN #518 reported CNA #561 had just come to her, something had happened in the room with CNA #555 and she did not want to tell her. LPN #536 asked RN #518 why CNA #561 did not tell her about this, as she was the nurse on the 300 and 400 halls. LPN #536 went to go talk to CNA #561. CNA #561 told her that she and CNA #555 were in Resident #49's room getting him dressed around 10:00 A.M. and CNA #555 put her hands on his shoulder, shook him and was mocking him. LPN #536 explained that Resident #49 said the same words over and over due to his cognitive decline. CNA #561 also told her CNA #555 argued with Resident #23. LPN #536 stated by this time it was 3:30 P.M. or so and she told CNA #561 to write a statement. LPN #536 stated she and RN #518 spoke to Resident #23, who denied the allegation but stated CNA #555 was upset there was no linen for his shower. LPN #536 stated she contacted UM/LPN #532, who was the nurse on call, before dinner [4:30 P.M. to 5:00 P.M.] to report that RN #518 told her CNA #561 had told her CNA #555 did something to Resident #49. At that point, CNA #555 was already out of the facility as her shift was over at 3:00 P.M. but she had written a statement before leaving. LPN #536 confirmed CNA #555 was not removed immediately from the facility as CNA #561 did not report the allegation timely. Phone interview on 08/28/25 at 3:17 P.M. with CNA #555 revealed she currently worked the front of the facility and had not worked in the back of the facility for several weeks. When asked why this was, CNA #555 reported she was accused of shaking Resident #49 by another staff member and was told to write a statement before she left at 3:00 P.M. that day [07/27/25]. CNA #555 verified she worked her entire shift on 07/27/25, from 7:00 A.M. to 3:00 P.M. CNA #555 stated she worked with Resident #49 in the morning and then was suspended after her shift that day. When she returned to work on 08/05/25, CNA #555 stated she was scheduled in the front of the facility and was told the allegations were unsubstantiated. When asked about the allegations involving Resident #23 and Resident #49, CNA #555 stated Resident #23 was like a child and called her grandma and denied the (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	allegations. Interview on 08/28/25 at 4:00 P.M. with the Administrator confirmed CNA #555 worked her entire shift on 07/27/25 and did not go home early as the allegation of neglect/abuse was not reported timely. Interview on 08/28/25 at 5:06 P.M. with UM/LPN #532 revealed on 07/27/25 (no time given) LPN #536 called her to tell her CNA #561 came to her with concerns about CNA #555 including grabbing and shaking Resident #49 during care and saying 'okay, okay, okay,' then going into Resident #23's room and gave him attitude. At that time CNA #561 told CNA #555 to exit the room. UM/LPN #532 shared LPN #536 did not mention abuse but told her, I know I need to report this. UM/LPN #532 stated she called the DNS and they explained CNA #555 needed to go home but she had already exited the building at that time. UM/LPN #532 reported Regional Nurse Consultant (RNC) #598 became involved and someone at the corporate level initiated a SRI. UM/LPN #532 stated all of the staff floated across the units and CNA #561 was the only witness to the allegation and shared CNA #555 was moved to the front of the facility post-allegation as an intervention. Phone interview on 08/29/25 at 10:08 A.M. with CNA #561 revealed on 07/27/25, CNA #555 helped her with Resident #49's care as she dressed from his feet up and CNA #555 dressed him from his head down around 12:30 P.M. When she looked up, CNA #561 was shaking Resident #49 for two minutes as he fought her while she tried to put his shirt on. CNA #561 stated Resident #49 was holding on to CNA #555's arms and was not hitting her and then CNA #555 stated, Oh my God, why the (expletive) can't you just work with me? Why do you have to fight with me? CNA #561 stated she told CNA #555, I need you to breathe, this is not worth your license, and shared CNA #555 replied back, (Expletive) this place, I don't care about this place. CNA #561 was questioned regarding CNA #555's verbal statements as these were not in her written statement which she verified during the interview and stated she informed the DNS of this content while she wrote her statement. After the incident, she walked out of Resident #49's room and CNA #555 stood in front of LPN #536 so she did not feel she could talk to LPN #536. CNA #561 stated she then spoke to RN #518 in the parking lot who told her to report the incident. Later, she overheard CNA #555 cursing at Resident #23 while trying to clean him up and she intervened and told CNA #555 to just go. CNA #561 stated she spoke to Resident #23 who stated he does not like when CNA #555 screams. CNA #561 then stated she reported these incidents to LPN #536 (time not given) and shared CNA #555 did not leave right away but she did not know when CNA #555 actually left. Interview on 09/02/25 at 8:46 A.M. with the DNS revealed on 07/27/25 after 3:00 P.M. UM/LPN #532 called her and they ended up doing a three-way call with LPN #536. At this time, CNA #555 had already left as it was shift change. During the call, it was shared CNA #555 was rude to Resident #23 and shook Resident #49's shoulder. Someone (not identified) said RN #518 was told first, but then it went to LPN #536 who stated 'I just found out' and had called UM/LPN #532 first. The DNS confirmed RN #518 never called her or reported the allegation to her. The DNS stated she then had to call RNC #598 to get an SRI started as the facility did not have an Administrator during the weekend the allegation occurred. Interview on 09/02/25 at 9:29 A.M. with the Administrator revealed she officially started at the facility on 07/29/25 and that is when she became aware of the SRI involving Resident #23 and Resident #49 on 07/27/25. When asked about the timeline regarding the incident and the reporting of the allegation, the Administrator stated it seemed like it took most of the day for CNA #561 to report the allegation which was not immediate as required. Follow-up interview on 09/02/25 at 4:40 P.M. with the Administrator regarding the SRI on 07/27/25 confirmed multiple facility staff did not report the allegation of abuse/neglect immediately as required. Review of the facility policy, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation, revised 06/05/25 and effective 07/01/25 revealed residents have the right to be free from abuse, neglect, exploitation and misappropriation of resident/patient property. Care team members should immediately report all such allegations to the Administrator and to Department of Health (DOH) in accordance with the procedures in this policy. [The facility would ensure] all care team members would report all incidents and allegations of abuse, neglect, mistreatment, exploitation and misappropriation of resident/patient property, as well as notifying the Administrator, Director of Nursing, or charge nurse immediately upon (continued on next page)		

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identification of any new injuries. If a care team member is accused or suspected, the facility should immediately remove the care team member from the facility and schedule pending the outcome of the investigation. All incidents and allegations of abuse, neglect, exploitation, mistreatment and misappropriation of resident/patient property and all injuries of unknown source must be reported immediately to the Administrator/designee and they should be notified in person, via telephone, text message or phone call. If any form of abuse is alleged, the Administrator/designee will notify DOH immediately but no later than two hours after the allegation is made or the serious bodily injury is identified.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of a self-reported incident (SRI), review of the facility's investigation and review of the facility policy, the facility failed to thoroughly investigate allegations of abuse and neglect. This affected two residents (#23 and #49) of three residents reviewed for abuse and neglect. Facility census was 55. Findings include: Review of Resident #49's medical record revealed an admission date of 03/01/24 and diagnoses including Alzheimer's disease, dysphagia, constipation, generalized anxiety disorder, vascular dementia with behavioral disturbance, psychotic disorder and mood affective disorder. Resident #49 had a legal guardian and was receiving hospice services. Review of Resident #49's quarterly minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #49 had cognitive impairment, displayed physical and verbal behaviors one to three days in the look-back period and was dependent for upper body and lower body dressing. Review of Resident #23's medical record revealed an admission date of 08/11/22 and diagnoses including Asperger's syndrome, morbid obesity, depression, type two diabetes and insomnia. Resident #23 was his own responsible party. Review of Resident #23's quarterly MDS 3.0 assessment dated [DATE] revealed Resident #23 was cognitively intact and did not display behaviors. Resident #23 was dependent for dressing, personal hygiene and dressing and required partial/moderate assistance for rolling. Review of a SRI dated 07/27/25 and submitted to the State Agency (SA) at 4:23 P.M. revealed an allegation of staff to resident neglect involving Certified Nursing Assistant (CNA) #555, Resident #23 and Resident #49. Licensed Practical Nurse (LPN) #536 informed Unit Manager (UM)/LPN #532 that CNA #561 expressed concern that CNA #555 who was working with her had yelled at and shook Resident #49 while dressing him in her presence. CNA #561 also reported that CNA #555 went into Resident #23's room and argued with him. The allegation was not reported to another agency. The facility determined the allegation of neglect to be unsubstantiated as Resident #23 refuted the allegation of verbal abuse and disputed information from CNA #561 could not be verified. Review of a timeline included in the facility's SRI investigation revealed on 07/27/25 (time not given), LPN #536 contacted UM/LPN #532 to report an allegation of abuse that was reported to her by CNA #561. CNA #561 reported that CNA #555 shook Resident #49 and yelled at him while they were dressing the resident (time not given). CNA #561 reported that CNA #555 had yelled out in a mocking manner saying okay, okay, okay which is what Resident #49 was known for repeating as he had limited verbalization due to his Alzheimer's diagnosis. It was reported that both CNAs then went to Resident #23's room (time not given) to assist with care. UM/LPN #532 instructed LPN #536 to ask CNA #555 to leave immediately (time not given) then go into Resident #23's room to ask about the reported allegation. Resident #23 denied concerns with staff, denied any CNA yelling or arguing with him and indicated he felt safe. UM/LPN #532 instructed LPN #536 to complete pain assessments on Resident #23 and Resident #49 and to complete skin assessments on all residents on the 300 and 400 halls. Resident #49's skin assessment was negative. UM/LPN #532 notified the Director of Nursing Services (DNS) and Regional Director of Operations (RDO) of the allegation, an SRI was initiated and an investigation began. Continued review of the facility's timeline revealed on 07/28/25, UM/LPN #532 assessed Resident #23 and Resident #49 who were within normal limits. Social Service Director (SSD) #559 observed and interviewed residents on the 300 and 400 halls with no findings. Continued review of the facility's timeline revealed on 07/29/25, Resident #23 had a care conference and did not voice any concerns or issues. SSD #559 also met with Resident #23 who was resting. SSD #559 met with Resident #23 again on 07/30/25 who was resting and smiled when he asked how he was feeling. Review of an undated witness statement authored by CNA #561 revealed it was directed towards the facility's previous Human Resource Director (HRD), UM/LPN #532 and the DNS and revealed the following information: I am writing to formally report a situation that I believe violated workplace policies and may have impacted my sense of safety and professionalism on the job. On (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	07/27/25 (no time given) I witnessed my co-worker [CNA #555] yell and shake a dementia patient [Resident #49] as we were dressing him. Then (no time given) the next patient [Resident #23] [CNA #555] argued with and I stepped in to diffuse the situation. The coworker cooled down but I reported this to two different nurses, UM/LPN #532 and the DNS. I believe it is important to bring this forward in the spirit of maintaining a respectful and accountable but mostly safe workplace. I am willing to cooperate with any investigation or discussion necessary. Please confirm receipt of this message and let me know the next steps. Review of a witness statement dated 07/27/25 and authored by CNA #555 revealed the following information: Today I help my co-worker with Resident #49 (no time given). Everything went good, she put his pants on and I put his shirt on and got him up in his chair. Additional writing on this statement dated 07/29/25 and signed by the Administrator revealed the following information: I knew the other CNA and did not expect anything. I don't know why she would make accusations. I have spent 14 years working at the facility. There was another accusation in the past made by the resident (not specified) a few months ago. I put his [Resident #49's] shirt on. I did not shake him. I may have said 'okay, okay,' but not to mock him - that's just how he communicates. I have never had a problem with the other CNA. I spent much of the day asking where the CNA was and the nurse (not specified) would say no. And I stated, 'I haven't either.' I don't know, I have worked here a long time and would never abuse a resident. I don't do this job for the Administrator or the DNS, I do it for the person in the bed. Review of a witness statement dated 07/27/25 and authored by Registered Nurse (RN) #518 revealed the following information: I was approached by CNA #561 (time not given) and she told me that she was in the room with CNA #555 changing Resident #49. She said CNA #555 was frustrated and shook Resident #49. She said she is about to be a nurse and that she would have to report it. Review of a witness statement dated 07/27/25 and authored by LPN #536 revealed the following information: CNA #561 came to me while I was walking down the hallway (time not given). CNA #561 stated while her and CNA #555 were in Resident #49's room she witnessed CNA #555 put her hands on Resident #49's shoulders and shake him, mocking him, saying 'okay, okay, okay.' I would like to add that I feel like CNA #561 was upset she was told by this nurse that she was working the 300 hall and the other CNA was working 400 hall by herself. I went in to speak to Resident #23 who stated nothing happened other than CNA #444 was moody and upset because she did not have any linen to do his bed bath. Additional writing present on LPN #536's statement that lacked a date and an author revealed that RN #518 reported to LPN #536 that something happened with CNA #555 between 9:30 A.M. and 10:00 A.M. which was late reporting and CNA #555 did an amazing job and never has issues. Review of a witness statement dated 07/27/25 and authored by LPN #578 denied witnessing abuse of any sort on 07/27/25 or any other days worked previously. Review of a witness statement dated 07/29/25 and authored by SSD #559 revealed she spoke with Resident #23 who was resting in bed and was alert and oriented times three. Resident #23 told SSD #559 that CNA #555 did not verbally abuse him and asked who the other CNA was that had come in and told him another resident had had an incident with CNA #555. Resident #23 stated he did not want to be put into this situation and stated he felt safe at the facility. Interview on 08/27/25 at 1:53 P.M. with Resident #23 revealed there was a CNA (not named) that was verbally abusive to him about four months ago and who had a snarky attitude. The CNA would make him wait, then not do what he requested. Resident #23 reported he had not seen the CNA in a while. Observation on 08/28/25 at 12:42 P.M. revealed UM/LPN #532 was interacting with Resident #49 who was seated in a Broda chair on the secured unit. The surveyor asked Resident #49 how lunch was and Resident #49 put his head down and did not respond. Resident #49 was not interviewable due to cognition. Interview on 08/28/25 at 1:45 P.M. with RN #518 revealed on 07/27/25, she was working in the front of the facility on the 200 hall and CNA #555, CNA #561 and LPN #536 were in the back of the facility. Around 2:00 P.M. RN #518 was on her lunch and CNA #561 approached her while she was in her car. CNA #561 stated she thought she had to report something as CNA #555 was in a room with her and grabbed Resident #49 and shook him. RN #518 told CNA #561 to report the allegation. RN #518 stated (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #536 had called a member of management staff at some point on 07/27/25 and they were gathering statements from anyone CNA #555 and CNA #561 spoke to. Interview on 08/28/25 at 2:00 P.M. with CNA #573 revealed on 07/27/25, she was working in the front of the facility and recalled CNA #561 said CNA #555 said harsh words to an unknown resident. Around 3:00 P.M. CNA #561 appeared shook and came to her, telling her she reported this to LPN #536 and RN #518 but did not report it right away. CNA #573 reported she never was asked to write a statement regarding the allegation even as she was working the date and shift the allegation occurred within. Interview on 08/28/25 at 2:23 P.M. with CNA #565 revealed she worked on 07/27/25 in the front of the facility but denied writing a statement regarding the allegation that occurred on that date and shift. Interview on 08/28/25 at 2:41 P.M. with LPN #578 revealed she had worked all four halls during her time at the facility and denied knowledge of the allegation on 07/27/25 during that date and shift. Interview on 08/28/25 at 2:56 P.M. with LPN #536 revealed she worked on 07/27/25 in the back of the facility. Around 2:30 P.M. to 3:00 P.M. she went outside to take a smoke break and RN #518 told her CNA #561 was going to tell her that CNA #555 did something to Resident #49. LPN #536 stated she asked RN #518 what was she talking about and RN #518 reported CNA #561 had just come to her, something had happened in the room with CNA #555 and she did not want to tell her. LPN #536 went to go talk to CNA #561. CNA #561 told her that she and CNA #555 were in Resident #49's room getting him dressed around 10:00 A.M. and CNA #555 put her hands on his shoulder, shook him and was mocking him. LPN #536 explained that Resident #49 said the same words over and over due to his cognitive decline. CNA #561 also told her CNA #555 argued with Resident #23. LPN #536 stated by this time it was 3:30 P.M. or so and she told CNA #561 to write a statement. LPN #536 stated she and RN #518 spoke to Resident #23, who denied the allegation but stated CNA #555 was upset there was no linen for his shower. LPN #536 stated she contacted UM/LPN #532, who was the nurse on call, before dinner [4:30 P.M. to 5:00 P.M.] to report that RN #518 told her CNA #561 had told her CNA #555 did something to Resident #49. At that point, CNA #555 was already out of the facility as her shift was over at 3:00 P.M. but she had written a statement before leaving. LPN #536 stated they got statements from everyone on 07/27/25 for the 7:00 A.M. to 3:00 P.M. shift. Phone interview on 08/28/25 at 3:17 P.M. with CNA #555 revealed she currently worked the front of the facility and had not worked in the back of the facility for several weeks. When asked why this was, CNA #555 reported she was accused of shaking Resident #49 by another staff member on 07/27/25. CNA #555 stated she worked with Resident #49 in the morning and then was suspended after her shift that day. When she returned to work on 08/05/25, CNA #555 stated she was scheduled in the front of the facility and was told the allegations were unsubstantiated. When asked about the allegations involving Resident #23 and Resident #49, CNA #555 denied the allegations. Interview on 08/28/25 at 5:06 P.M. with UM/LPN #532 revealed on 07/27/25 (no time given) LPN #536 called her to tell her CNA #561 came to her with concerns about CNA #555 including grabbing and shaking Resident #49 during care and saying 'okay, okay, okay,' then going into Resident #23's room and gave him attitude. At that time CNA #561 told CNA #555 to exit the room. UM/LPN #532 shared LPN #536 did not mention abuse but told her, I know I need to report this. UM/LPN #532 stated she called the DNS and they explained CNA #555 needed to go home but she had already exited the building at that time. UM/LPN #532 reported Regional Nurse Consultant (RNC) #598 became involved and someone at the corporate level initiated a SRI. UM/LPN #532 stated all of the staff floated across the units at the facility. For the SRI, CNA #561 was the only witness to the allegation and shared CNA #555 was moved to the front of the facility post-allegation as an intervention. Phone interview on 08/29/25 at 10:08 A.M. with CNA #561 revealed on 07/27/25, CNA #555 helped her with Resident #49's care as she dressed from his feet up and CNA #555 dressed him from his head down around 12:30 P.M. When she looked up, CNA #561 was shaking Resident #49 for two minutes as he fought her while she tried to put his shirt on. CNA #561 stated Resident #49 was holding on to CNA #555's arms and was not hitting her and then CNA #555 stated, Oh my God, why the (expletive) can't you just work with me? Why do you have to fight with (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	me? CNA #561 stated she told CNA #555, I need you to breathe, this is not worth your license, and shared CNA #555 replied back, (Expletive) this place, I don't care about this place. CNA #561 was questioned regarding CNA #555's verbal statements as these were not in her written statement which she verified during the interview and stated she informed the DNS of this content while she wrote her statement. After the incident, she walked out of Resident #49's room and CNA #555 stood in front of LPN #536 so she did not feel she could talk to LPN #536. CNA #561 stated she then spoke to RN #518 in the parking lot who told her to report the incident. Later, she overheard CNA #555 cursing at Resident #23 while trying to clean him up and she intervened and told CNA #555 to just go. CNA #561 stated she spoke to Resident #23 who stated he does not like when CNA #555 screams. CNA #561 then stated she reported these incidents to LPN #536 (time not given). Interview on 09/02/25 at 8:46 A.M. with the DNS revealed on 07/27/25 after 3:00 P.M. UM/LPN #532 called her and they ended up doing a three-way call with LPN #536. At this time, CNA #555 had already left as it was shift change. During the call, it was shared CNA #555 was rude to Resident #23 and shook Resident #49's shoulder. Someone (not identified) said RN #518 was told first, but then it went to LPN #536 who stated 'I just found out' and had called UM/LPN #532 first. The DNS stated she then had to call RNC #598 to get an SRI started as the facility did not have an Administrator during the weekend the allegation occurred. During the interview, the DNS was questioned if the police were contacted regarding the allegation of neglect/abuse and indicated police should be called with SRIs. The DNS was informed at this time there was no evidence the police were contacted with the SRI and she did not disagree. Interviews on 09/02/25 at 9:29 A.M. and 4:40 P.M. with the Administrator revealed she officially started at the facility on 07/29/25 and that is when she became aware of the SRI involving Resident #23 and Resident #49 on 07/27/25. When asked about if the police were involved with the allegation, the Administrator stated they (not specified) asked the residents/responsible parties if they wanted the police contacted and stated UM/LPN #532 had reported to her the responsible parties did not want the police called. When asked about the lack of statements from all staff working on the affected date and shift for the SRI, the Administrator stated they interviewed where the allegation occurred and confirmed statements were not collected from CNA #565 and CNA #573. When asked about the lack of resident statements or skin sweeps on the 100 and 200 halls, as many care staff floated across the whole facility, the Administrator confirmed no residents on the 100 or 200 halls had their skin checked or were interviewed regarding the allegation. When asked if personnel files were reviewed as part of the SRI, the Administrator confirmed she did not review personnel files even as the facility policy directed to do so. The Administrator verified the overall SRI on 07/27/25 was not thoroughly investigated as required. Review of the facility policy, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation, revised 06/05/25 and effective 07/01/25 revealed residents have the right to be free from abuse, neglect, exploitation and misappropriation of resident/patient property. Once the Administrator and the Department of Health (DOH) are notified, an investigation of the alleged violation will be conducted. The person investigating the incident should generally take the following actions: Interview the resident/patient, the accused, and all witnesses. Witnesses generally include anyone who: witnessed or heard the incident, came in close contact with the resident the day of the incident (including the other patients/residents, family members) and employees who worked closely with the accused employees and/or alleged victim the day of the incident. If there are no direct witnesses, the interviews may be expanded. Consider interviews with all care team members on the shift or the unit as well as other residents/patients on the unit. If the allegation involves abuse/neglect interview other residents to determine if they may have been affected by the accused care team member. If the accused is a care team member, employment records are reviewed. If the facility suspects that a crime has been committed, it will report that suspicion to law enforcement. If the resident has serious bodily injury, law enforcement must be notified within two hours; without serious bodily injury, law enforcement must be notified within 24 hours.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, observation, and mechanical lift policy the facility failed to ensure Resident #30 was safely transferred with a Hoyer (mechanical) lift to prevent a fall. This affected one resident (Resident #30) of four residents reviewed for accidents. The facility census was 55. Findings include: Review of the medical record for Resident #30 revealed an admission date of 08/20/25 with diagnosis that include: urinary tract infection, type 2 diabetes mellitus with diabetic nephropathy, catatonic disorder, dementia without behavioral disturbance, metabolic encephalopathy, dysphagia and altered mental status. Review of Morse Fall Scale dated 08/20/25 revealed Resident #30 was a high risk for falling. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #30 cognition was moderately impaired and was dependent on staff for transfers from the chair to the bed. Review of Resident #30 medical chart revealed resident had fallen on 08/21/25, 08/30/25, 08/31/25, and 09/03/25. Review of Resident #30's care plan dated 09/02/25 revealed Resident #30 required assistance with activities of daily living impaired mobility, weakness, debility, catatonic and cognition. An intervention dated 08/22/25 with a revised date of 09/02/25 revealed Resident #30 required a mechanical lift for transfers usually a Hoyer lift. Review of the nursing progress note dated 09/03/25 at 1:15 P.M. authored by Licensed Practical Nurse (LPN) #578 revealed she was preparing to assist Certified Nursing Assistant (CNA) #555 on the left side of the bed when CNA #555 moved the hoist, the front left hook let loose and Resident #30 fell out of the hoist, hitting her head on the floor. Resident #30 stated her head hurt a little and the resident was able to move all four extremities without limitations. Resident was sent out to the emergency room. Review of Resident #30's computerized tomography (CT Scan) from the hospital dated 09/03/25 at 12:04 P.M. revealed no evidence of an acute infarct or other acute parenchymal process. Resident #30's medical record revealed the resident returned to the facility with no noted injuries. Interview on 09/04/25 at 11:31 A.M. with CNA #555 revealed Resident #30 hoist pad was hooked up to the hoist lift, she checked to make sure hoist pad was hooked up to hoist, and lifted Resident #30 with the hoist. Resident #30 came out of the sling and went to the floor. CNA #555 revealed Resident #30 does not want to be here and that she thought the resident tried to move the hoist strap off. CNA #555 does not remember the last time she had training for the hoist. Interview on 09/04/25 at 12:06 P.M. with LPN #578 revealed she was assisting CNA #555 in Resident #30's room. LPN #578 was on the left side of the bed and Resident #30 and CNA #555 were by the door when the front left hook gave out and Resident #30 did a somersault out of the hoist lift and bumped her head. LPN #578 did not witness CNA #555 check hooks because she was in the bathroom gathering supplies at the time. LPN #578 checked hoist pad after the fall and all straps were in working order. LPN #578 revealed she had not been trained on the hoist during orientation. Review of the facility policy titled, Transfers and Mechanical Lifts Policy dated 01/02/24, revealed bullet 10: two staff members must be utilized when transferring residents with a mechanical lift. Further, bullet 12 revealed: The staff must demonstrate competency in the use of the mechanical lifts prior to use and annually with documentation of that competency placed in their education file. This deficiency represents non-compliance investigated under Complaint Number 1364232.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to ensure Resident #7, who received hemodialysis (HD) three times a week, was evaluated before and after dialysis treatments. This affected one resident (Resident #7) of one resident received for HD. Facility census was 55. Findings include: Record review revealed Resident #7 was admitted to the facility on [DATE] with diagnoses which included diabetes, chronic kidney disease (CKD) - Stage3, major depressive disorder, generalized anxiety disorder, dependence of renal dialysis, heart disease, gastroesophageal reflux disease (GERD), and Vitamin D deficiency. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, for Resident #7, dated 06/20/25 revealed the resident was cognitively intact. Review of the physician orders for Resident #7, dated 04/21/25, revealed that a pre and post assessment needs to be completed on dialysis days. On 09/03/25 at 5:00 P.M., a review of Dialysis PRE/POST Communication Record - V 2 from 09/01/25, 09/02/25, and 09/03/25 revealed the assessments were not completed. The incomplete assessments were confirmed on 09/04/25 at 2:06 P.M. with Regional Nurse #599. Review of Dialysis binder for Resident #7 revealed only blank Dialysis forms, no completed forms. The empty binder was confirmed on 09/04/25 at 2:10 P.M. by Regional Nurse #598. Review of facility policy titled Dialysis, updated on 12/12/23, asserted the ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interview, the facility failed to ensure medications to treat diabetes and to improve glucose control were administered as ordered by the physician. This affected one (Resident #61) of six reviewed for medication administration. The facility census was 55. Findings include: Review of the medical record for Resident #61 revealed an admission date of 12/21/24 with diagnoses including diabetes mellitus, hypertension and heart failure. Review of the physician's orders for Resident #61 revealed an order for Insulin Lispro (medication for hyperglycemia) 55 units in the morning and at night dated 12/22/24 and Humalog (medication for hyperglycemia) sliding scale insulin to be given per the blood sugar to be done in the morning, at lunch, at dinner and at bedtime dated 12/22/24. Review of the Medication Administration Record for December 2024 for Resident #61 revealed his Insulin Lispro was not administered on 12/23/24 in the morning and Humalog sliding scale was not administered on 12/23/24 at lunch. Review of Resident #61's care plan dated 12/23/24 revealed he had diabetes mellitus and staff should administer medications as ordered. Interview on 08/28/25 at 11:11 A.M. with the Director of Nursing Services verified Resident #61's insulin was not administered as ordered on 12/23/24. Review of the facility policy titled, Medication Administration, dated 01/02/24, revealed medications were to be administered as ordered. This deficiency represents non-compliance investigated under Complaint Number 1364233 and Complaint Number 1364234.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on record review, observation and interview, the facility failed to ensure medications were properly stored and secured. This affected two (Residents #10 and #55) of two residents reviewed for improperly stored medications. The facility had a census of 55 residents. Findings include: Observation on 08/27/25 at 9:08 A.M. of medication administration with Registered Nurse (RN) #564 to Resident #55 revealed two bottles of Nystatin Powder (antifungal medication used to treat fungal or yeast infections) on her television stand. Once the medication administration was completed and when leaving room, noted Resident #55's roommate, Resident #10, to have a bottle of Nystatin Powder on her tray table. Interview on 08/27/25 at 9:08 A.M. with RN #564 verified medications should not have been in either residents' room as the physician had not ordered medications to be left at bedside for the resident to self-administer. Review of the facility policy titled, Medication Administration, dated 01/02/24, revealed medications were not to be left unattended in the resident's room.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to maintain accurate and complete resident records. This affected three residents (#49, #60, #64) of 23 resident records reviewed for documentation. Facility census was 55. Findings include: 1. Review of Resident #49's medical record revealed an admission date of [DATE] and diagnoses including Alzheimer's disease, dysphagia, constipation, generalized anxiety disorder, vascular dementia with behavioral disturbance, psychotic disorder and mood affective disorder. Review of Resident #49's quarterly minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #49 had cognitive impairment, displayed physical and verbal behaviors one to three days in the look-back period and was dependent for upper body and lower body dressing. Review of Resident #49's physician's orders revealed an order dated [DATE] for Lorazepam oral tablet 0.5 milligrams (mg) give one tablet by mouth every four hours as needed for anxiety. Review of a hospice note dated [DATE] at 1:00 A.M. revealed the facility contacted hospice to clarify Resident #49's order for Lorazepam. Hospice reviewed Resident #49's medication list and verified Resident #49's Lorazepam order was active. Review of Resident #49's [DATE] Medication Administration Record (MAR) revealed the Lorazepam was administered on [DATE] at 10:53 A.M. and was ineffective. Review of Resident #49's nurses' notes prior to [DATE] and back to [DATE] revealed no mention of Lorazepam or behaviors that would indicate the need to administer Lorazepam. Interview on [DATE] at 12:21 P.M. with Unit Manager (UM)/Licensed Practical Nurse (LPN) #532 and Regional Nurse Consultant (RNC) #598 revealed the facility expectation was to document resident behaviors, document the request from hospice for a new medication and to document new medications being started. UM/LPN #532 verified the above lack of documentation surrounding Resident #49's behaviors, need for a new medication and starting of a new medication during the interview. 2. Review of Resident #64's closed medical record revealed an admission date of [DATE] and diagnoses including personality disorder, breast cancer, insomnia and mild cognitive impairment. Review of Resident #64's death-in-facility MDS 3.0 assessment dated [DATE] revealed Resident #64 expired in the facility that date. Review of the last progress note in Resident #64's medical record revealed a note dated [DATE] at 3:48 A.M. and authored by Registered Nurse (RN) #562 revealed the hospice nurse came to evaluate the resident on [DATE] around 9:30 P.M. New orders received for nystatin oral suspension 100000 units/milliliter (mL), apply 5 mL via swab to oral cavity four times a day for seven days and Isosource 1.5, give 300 mL via peg tube every six hours. The medical record did not indicate when Resident #64 had an absence of vital signs or actually expired in the facility. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interviews on [DATE] at 9:40 A.M. and 11:51 A.M. with RNC #598 verified there should be a progress note regarding a resident's death which should indicate when the resident had a lack of vital signs and was pronounced deceased . RNC #598 also confirmed there was no documentation to show that hospice and the family were notified regarding Resident #64's passing within Resident #64's medical record. Review of the facility policy, Documentation in the Medical Record, dated [DATE], revealed each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate and timely documentation. Documentation shall be completed at the time of service but no later than the shift in which the assessment, observation or care service occurred. 3. Review of the medical record for Resident #60 revealed an admission date of [DATE] with diagnoses including dementia, hypertension and chronic obstructive pulmonary disease. Review of Resident #60's census revealed she was discharged from the facility on [DATE]. Review of the nursing progress notes for [DATE] revealed there was no documentation as to what time Resident #60 expired or if the physician and guardian were notified of her passing. On [DATE] at 8:28 P.M. there was a medication note that stated medication was not given due to resident expiring. Interview on [DATE] at 2:10 P.M. with Registered Nurse (RN) #562 verified he had not documented when Resident #60 expired but had only documented her condition had declined earlier in the day. Interview on [DATE] at 11:11 A.M. with Director of Nursing Services verified staff had not thoroughly documented when Resident #60 had expired or if the guardian and physician had been updated on her expiring. Review of the facility policy titled, Documentation in the Medical Record, dated [DATE], revealed each resident's medical record should contain an accurate representative of the actual experiences of the resident. This deficiency represents non-compliance investigated under Complaint Number 1364233.		