STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365845	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rae Ann Suburban	29505 Detroit Rd Westlake, OH 44145

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, and medical record review, the facility failed to ensure preferences were followed regarding application of compression bandages. This affected one (#41) of one resident reviewed for preferences. The facility census was 79. Findings include: Review of the medical record for Resident #41 revealed he was admitted to the facility on [DATE] with diagnoses that included cellulitis, heart failure, and peripheral vascular disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #41 had a Brief Mental Status (BIMS) score of 12 that indicated he had moderate cognitive impairment. Review of the MDS assessment revealed Resident #41 required some assistance from staff for activities of daily living (ADLs). Review of the physician orders dated 12/05/24 revealed Resident #41 had an order in place to apply ACE wraps (compression bandages) to bilateral lower extremities before rising and remove at night two times a day for compression therapy and document refusals. Review of the care plan dated 04/30/25 revealed Resident #41 had skin impairment with interventions that included to monitor and treat as ordered. Review of the electronic medication administration record (EMAR) note dated 05/07/25 at 5:50 A.M. revealed Resident #41 refused to have ACE wraps applied due to wanting them applied after his shower. Review of the EMAR note dated 05/14/25 at 6:25 A.M. revealed Resident #41 refused to have ACE wraps applied after his shower. Review of the EMAR note dated 05/17/25 at 6:36 A.M. revealed Resident #41 refused to have ACE wraps applied and wanted them after his morning shower. Review of the EMAR note dated 05/27/25 at 6:27 A.M. revealed Resident #41 refused his ACE wraps due to wanting to take his shower first before having them applied. Review of the EMAR note dated 05/28/25 at 6:53 A.M. revealed Resident #41 wanted his ACE wraps applied after his shower. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 06/02/25 at 2:11 P.M. with Resident #41 revealed staff were to wrap his legs twice a day, but they were not doing it. Resident #41 revealed he preferred his legs to be wrapped after he took his shower due to not having the wraps get wet or having to apply and reapply. Resident #41 lower bilateral legs appeared red in color and swollen. Interview on 06/02/25 at 2:21 P.M. with Certified Nurse Aide (CNA) #710 revealed Resident #41 preferred to have his legs wrapped after his showers, but nurses did not always follow his preference. Interview and observation on 06/02/25 at 3:06 P.M. with Resident #41 and the Director of Nursing (DON) revealed Resident #41 was seated at the reception desk in his wheelchair. Resident #41's legs were observed to be unwrapped with a knee patch dated 06/02/25, for the current date. Resident #41 revealed he had a shower, but his legs were not wrapped, as preferred, but staff applied his other dressing. Resident #41 revealed due to wanting his legs wrapped after his shower, staff did not apply them because they wanted to do it in the early morning. The DON stated Resident #41 refused to have his legs wrapped; however, Resident #41 intervened and stated he refused to have his legs wrapped before his showers due to wraps getting wet or ruined and it made sense to apply after being showered and dressed. The DON confirmed and verified Resident #41 legs were not wrapped and staff were not honoring his preferences.

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident and resident representative interview, staff interviews, and facility policy review, the facility failed to ensure requests for medical records were honored in a timely manner. This affected one (#78) of one residents reviewed for medical record requests. The facility census was 79. Findings include: Review of the medical record for Resident #78 revealed she was admitted to the facility on [DATE] with diagnoses that included encephalopathy, mesothelioma, and type II diabetes. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #78 had a Brief Interview for Mental Status (BIMS) score of six that indicated the resident was cognitively impaired. Review of the MDS assessment revealed Resident #78 required some assistance from staff for activities of daily living (ADLs). Review of the progress note dated 05/28/25 at 12:31 P.M. revealed Registered Nurse (RN) #746 discussed with Resident #78 and Resident #78's sister a request for medical records. Review of the progress note dated 05/29/25 at 12:26 P.M. revealed RN #746 spoke with Resident #78's elderly advocate, who was in the process of obtaining guardianship, in regard to requested medical records. Review of the progress note dated 05/29/25 at 3:04 P.M. revealed Resident #78's elderly advocate called demanding copies of Resident #78 requested medical records. Review of the progress note dated 05/30/25 at 10:46 A.M. revealed RN #746 talked to Resident #78 about signing a release for medical records in accordance to facility policy. Resident #78 refused to sign form. Review of the progress note dated 05/30/25 at 1:24 P.M. revealed the Administrator spoke with Resident #78's elderly advocate in regard to release of medical records. Resident #78's elderly advocate informed the Administrator that Resident #78 would sign the form in her presence. The Administrator stated the facility would be following facility protocols in regard to medical records release. Review of the progress note dated 06/05/25 at 1:11 P.M. revealed RN #746 informed Resident #78 she could review her medical records with her but Resident #78 refused. RN #746 revealed Resident #78's release for copies of her medical record would be available on 06/06/25. Review of the progress note dated 06/06/25 at 12:49 P.M. revealed Resident #78 was given her medical records which were approved by the corporate compliance office. (continued on next page)

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/05/25 at 1:23 P.M. with Resident #78's elderly advocate revealed she and Resident #78 had been attempting to obtain Resident #78 medical records to continue the process of discharge and getting services in place required in the community. Resident #78's elderly advocate revealed Resident #78 signed medical record release form and also requested copies to be given to her; however, the facility refused to provide requested information. Interview on 06/05/25 at 3:47 P.M. with RN #746 revealed if a resident requested medical records, there was a form to sign, which was then sent to the corporate compliance office and returned within 48 to 72 hours. RN #746 revealed Resident #78 requested her medication and treatment administration record but was denied by the corporate compliance office. RN #746 stated she was informed by the corporate compliance office that resident medication and treatment administration records are not provided regardless if requested or placed on the medical release form. RN #746 revealed she did what the corporate compliance office told her to do. RN #746 confirmed and verified Resident #78 requested her full and complete medical record and was not being provided with the medication and treatment administration records. Interview on 06/09/25 at 12:15 P.M. with Resident #78 and Resident #78's elderly advocate revealed Resident #78 was given some of her medical records but not what was requested. Interview revealed Resident #78 requested her medication administration records and treatment administration records and was denied access to both. Follow-up interview on 06/09/25 at 2:03 P.M. with RN #746 revealed she provided Resident #78 with her medical records on 06/06/25. RN #746 revealed she only provided Resident #78 with what she was told to give by the corporate compliance office. RN #746 confirmed and verified Resident #78 did not receive all of her requested medical record including the medication and treatment administration records. Interview on 06/09/25 at 3:03 P.M. with the Administrator revealed residents were allow to request their medical records by completing the medical release form. The Administrator revealed once the form was sent to the corporate compliance office and/or legal counsel, they decided what the resident could have. The Administrator confirmed and verified the medication and treatment administration records were not able to be released to residents per corporate and legal counsel. Review of the facility document titled, Release of Information, revised November 2009, revealed the facility had a policy in place that all information contained in the medical record were confidential and only released by the written consent of the resident and/or legal representative, can be released to anyone the resident wishes, and may have access within 24 hours after request and hard copies after 48 hours.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and staff interview, the facility failed to ensure Notice of Medicare Non-Coverage (NOMNC) documents contained all required information. This affected three (#12, #75, and #139) of three residents reviewed for beneficiary notices. The facility census was 79. Findings Include: 1. Review of Resident #12's NOMNC form for services ending 02/26/25, and signed 02/21/25, revealed the notice contained no specific information about what services would be discontinued. 2. Review of Resident #75's NOMNC form for services ending 02/17/25, and acknowledge by the resident's family via telephone on 02/13/25, revealed the notice contained no specific information about what services would be discontinued. The area on the form that discussed which services would be discontinued was blank. 3. Review of Resident #139's NOMNC form for services ending 04/08/25, and signed 04/06/25, revealed the notice contained no specific information about what services would be discontinued. The area on the form that discussed which services would be discontinued was blank. Social Service Designee #782 verified the NOMNC forms for Resident #12, Resident #75, and Resident #139 lacked specific information about what services were being discontinued in an interview on 06/05/25 at 3:30 P.M.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident and staff interview, and Ombudsman interview, the facility failed to facilitate an orderly discharge when necessary medical supplies were not provided timely to a resident upon discharge. This affected one (#136) of four residents reviewed for discharges. The facility census was 79. Findings include: Review of the medical record for Resident #136 revealed an admission date of 01/31/25. The resident was discharged home on [DATE]. Diagnoses included acute respiratory failure with hypoxia, pneumonia, morbid obesity, and chronic obstructive pulmonary disease. Review of the Minimum Data Set (MDS) assessment, dated 03/24/25, revealed Resident #136 had intact cognition. Review of the physician order dated 03/17/25 revealed an order for oxygen at one to six liters via nasal cannula for the resident to maintain an oxygen saturation rate greater than or equal to 92 percent (%) every six hours as needed for cough, shortness of breath, wheezing, or resident request. Review of the clinical nurse practitioner (CNP) progress note dated 03/28/25 at 5:34 P.M. revealed Resident #136 was seen regarding her request for discharge from the facility. The resident would benefit from remaining in long-term care (LTC) but was insisting on leaving. The resident was educated on the benefits of remaining in the facility but was adamant about leaving. The resident was on supplemental oxygen and lung sounds were diminished throughout all fields. Review of the physician order dated 03/28/25 revealed an order that Resident #136 may discharge home on [DATE] with home health care, physical therapy, occupational therapy, speech therapy, nursing, and oxygen in place. Review of the discharge planning note dated 03/29/25 at 1:36 P.M. revealed Resident #136 was discharged home at 1:20 P.M. with her sister. Discharge instructions and prescriptions were explained and given to the resident along with a portable oxygen tank. Resident #136 did not express any concerns at that time. Review of the social services note dated 04/02/25 at 12:00 P.M., which was a late entry documented on 04/10/25 at 7:10 A.M., revealed the medical services/equipment company called back and informed Registered Nurse (RN) Manager/Social Service Designee (SSD) #746 that since the company did not follow-up with the facility and Resident #136 discharged on Saturday, RN/SSD #746 had to go to another oxygen company. Review of the social services note dated 04/01/25 at 2:00 P.M., which was a late entry documented on 04/10/25 at 7:08 A.M., revealed RN/SSD #746 was informed the insurance company for Resident #136 called due to oxygen not being delivered. RN/SSD #746 called the initial medical company and was told to leave a message, and they would get back in 24 hours. RN/SSD #746 called a different company, sent a facsimile (fax) of the discharge order information to them and Resident #136 was set up with oxygen within two hours of the company getting the paperwork. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the interdisciplinary Discharge summary dated [DATE] revealed the scripts for medications were sent with Resident #136. Pharmacy, home care services, and medical equipment, including supplemental oxygen were arranged. A telephone number to call was given and discharge instructions were explained. Under the Comments section it was stated the company was unable to deliver supplemental oxygen, a call was placed to a new company, and the oxygen was delivered. Interview on 06/04/25 at 3:45 P.M. with the Ombudsman revealed their office had been actively involved with Resident #136's discharge situation. The Ombudsman stated the resident's oxygen was ordered late Friday, 03/28/25 and information was sent to a durable medical equipment (DME) supplier. Resident #136 was anxious to get home on that Saturday. The resident was given a portable oxygen tank by the facility to take home since no oxygen was at home at the time of discharge. The oxygen never came on Monday and Resident #136 ended up calling another company to get oxygen on Tuesday. Interview on 06/05/25 at 12:14 P.M. with RN/SSD #746 revealed she sent the script for the oxygen to the DME supplier on 03/28/25 in the morning. The supplier called her back because they were having trouble reading/understanding the script. The RN/SSD had to read them the script and after it was read to them, they said every thing was okay. RN/SSD #746 stated the company did not say they could not supply the oxygen and did not say they needed a new script. The company did not call back so RN/SSD #746 thought everything was set. The DME supplier never contacted the facility and said the oxygen could not be sent. Resident #136 had not called and said the oxygen had not been delivered. Interview on 06/05/25 at 12:35 P.M. with the prior Administrator revealed the facility had a conversation with Resident #136 on Thursday 03/28/25. The resident was packed and ready to go. The prior Administrator also spoke with Resident #136's sister. The sister agreed the resident should stay longer for everything to be arranged. The resident said she was leaving Saturday no matter what because they could get the oxygen right away, they had the physician approve the concentrator to be sent home with the resident. On 06/05/25 at 12:40 P.M. RN/SSD #746 verified she did not confirm when the oxygen was to be delivered or called to confirm it had been delivered. RN/SSD #746 confirmed the second DME supplier was contacted on Tuesday, 04/01/25 and Resident #136 did not have oxygen on Saturday, Sunday, Monday, or Tuesday until the oxygen delivery. Interview on 06/05/25 at 2:17 P.M. with Resident #136 stated she called the facility over the weekend and got no answers, so the resident called the company for supplemental oxygen. This deficiency represents non-compliance investigated under Master Complaint Number OH00164296 and Complaint Number OH00162914.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure the preadmission screen and resident review (PASRR) status was coded correctly on the Minimum Data Set (MDS) assessment. This affected four (#9, #18, #34, and #58) of 23 residents identified by the facility with a level two mental illness currently residing at the facility. The facility census was 79. Findings Include: 1. Review of the medical record revealed Resident #9 was admitted to the facility on [DATE] with diagnoses that included schizophrenia, opioid dependence, and delusional disorder. Review of the PASRR level two assessment dated [DATE] revealed Resident #9 had a level two mental illness. Review of section A of the most recent comprehensive Minimum Data Set (MDS) 3.0 assessment of Resident #9 dated 04/03/25 revealed the facility answered No to the question asking, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability (mental retardation in federal regulation) or a related condition? 2. Review of the medical record revealed Resident #18 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, suicidal ideations, and adjustment disorder. Review of the PASRR level two assessment dated [DATE] revealed Resident #18 had a level two mental illness. Review of section A of the most recent comprehensive MDS 3.0 assessment of Resident #18 dated 09/19/24 revealed the facility answered No to the question asking, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability (mental retardation in federal regulation) or a related condition? 3. Review of the medical record revealed Resident #34 was admitted to the facility on [DATE] with diagnoses that included paranoid schizophrenia, muscle weakness, and chronic obstructive pulmonary disease. Review of the PASRR level two assessment dated [DATE] revealed Resident #34 had a level two mental illness. Review of section A of the most recent comprehensive MDS 3.0 assessment of Resident #34 dated 02/22/25 revealed the facility answered No to the question asking, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability (mental retardation in federal regulation) or a related condition? 4. Review of the medical record revealed Resident #58 was admitted to the facility on [DATE] with diagnoses that included schizophrenia, hypertension, and muscle weakness. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the PASRR level two assessment dated [DATE] revealed Resident #58 had a level to mental illness. Review of section A of the most recent comprehensive MDS 3.0 assessment of Resident #58 dated 08/06/24 revealed the facility answered No to the question asking, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability (mental retardation in federal regulation) or a related condition? Interview with MDS Nurse #762 on 06/04/25 at 3:00 P.M. verified Resident #9, Resident #18, Resident #34, and Resident #58 all were determined to have a level two mental illness by the state and confirmed the residents' PASRR statues were inaccurately assessed on their MDS assessments.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and facility policy review, the facility failed to ensure residents were provided with appropriate incontinence and perineal care. This affected one (#4) of two residents reviewed for bowel and bladder. The facility census was 79. Findings included: Review of the medical record for Resident #4 revealed an admission date of 03/19/25. Diagnoses included chronic obstructive pulmonary disease, pain in the right hip, and repeated falls. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 had intact cognition. Review of the bladder and bowel section revealed Resident #4 was always incontinent of bladder and bowel. Review of the care plan dated 04/03/25 revealed Resident #4 had self-care performance deficits with an intervention to assistance with toileting. Observation on 06/05/25 at 9:29 A.M. of perineal care for Resident #4 revealed Certified Nurse Aide (CNA) #703 gathered supplies, knocked on the door, provided privacy, and explained the procedure to the resident. CNA #703 used hand sanitizer from her pocket and donned gloves. CNA #703 placed four (4) washcloths in the bottom of the resident's sink with running water. CNA #703 then applied shampoo and body wash directly to the washcloths in the bottom of the sink with running water. CNA #703 then picked up the washcloths from the bottom of the sink and placed them in a basin with water. CNA #703 placed the basin on the resident's chair in her room. CNA #703 began to provide perineal care to Resident #4 and used one washcloth from the soapy water basin to cleanse the peri area. CNA #703 then used one washcloth from the soapy water basin for her rinse washcloth, then assisted Resident #4 to turn without patting the peri area dry. CNA #703 then removed one washcloth from the soapy water basin and cleansed the resident's buttocks. CNA #703 then removed one washcloth from the soapy basin to provide the rinse to buttocks. CNA #703 did not pat the resident's buttocks area dry. CNA #703 placed a new incontinence brief on Resident #4, positioned her, and placed call light in reach. CNA #703 doffed her gloves and performed hand hygiene. Interview on 06/5/24 at 9:35 A.M. with CNA #703 verified she did not perform the perineal care correctly. CNA #703 verified she should not have placed the clean washcloths in the bottom of the sink and she should have used the soap washcloths separate from the rinse washcloths. Interview on 06/05/25 at 10:20 A.M. with Registered Nurse (RN) Unit Manager #775 verified CNA #703 should not have placed the washcloths at the bottom of the sink due to infection control issues. RN Unit Manager #775 reported CNA #703 should have used one basin for soapy water and one basin for clean water and place the basins on the over bed tray per the policy. Review of facility policy titled, Perineal Care, revised February 2018, revealed the procedure was to place the equipment on the bedside stand and fill the wash basin one-half full of warm water and wet the washcloth and gently rinse and dry the area. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00162914.

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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 and staff interview, the facility failed to ensure its kitchen area was maintained in a clean and sanitary condition. This had the potential to affect all 77 residents receiving food from the kitchen. The facility identified two (#40 and #80) resident who received no food from the kitchen. The facility census was 79. Findings include: Observation during tour of the kitchen, conducted with Dietary Manager (DM) #796 on 06/02/25 from 9:15 A. M. through 9:48 A.M., revealed the the drawer under a food processor had crumbs and dirt in the drawer, one drawer in the food preparation area contained a dirty knife, the drawer with serving utensils had crumbs and debris in the bottom, and there were milk crates with containers of milk stored directly on the refrigerator floor. Further observation revealed there were no testing strips available to check the chemical level of the three-compartment sink or the sanitizer buckets. No staff were able to find any testing strips and there was no record was kept for checking sanitizer levels. Interview with DM #796 verified the above findings during the kitchen tour on 06/02/25 between 9:15 A.M. and 9:48 A.M.

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	365845	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rae Ann Suburban	29505 Detroit Rd Westlake, OH 44145

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

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. Based on review of the facility's arbitration agreement and staff interview, the facility failed to ensure its arbitration agreement did not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials and any other relevant advocacy agencies (id est (i.e.) State Survey Agency, Office of the State Long Term Care Ombudsman) regarding the arbitration process and/or outcome of the arbitration settlement. This had the potential to affect all 79 residents residing in the facility. The facility census was 79. Findings Include: Review of the facility's undated arbitration agreement revealed in section 16 titled, Confidentiality, revealed the arbitration shall be confidential and no party (facility or resident) shall disclose any details of the legal controversy, dispute, disagreement or claim between them or the arbitration process in general, without the consent of the other parties. The agreement further noted if necessary to collect an arbitration award through common pleas court, the parties agree to provide minimal details necessary in court pleadings to preserve the confidential nature of the arbitration procedures. The parties understand that confidentiality is one of the primary goals of this agreement and failure to abide by this provision would cause irreparable harm to the parties. Interview with the Administrator on 06/04/25 at 2:30 P.M. verified that facility's arbitration agreement contained language that would discourage residents and/or their representatives from communicating with federal, state, or local officials and any other relevant advocacy agencies (i.e. State Survey Agency, Office of the State Long Term Care Ombudsman) regarding the arbitration process and/or outcome of the arbitration settlement as noted above.

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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 observation, medical record review, staff interview, review of infection control tracking logs and COVID-19 tracking logs, review of the Centers for Disease Control and Prevention documents, and review of facility policies, the facility failed to adequately track infections within the facility and failed to ensure infection control measures were maintained related to obtaining blood glucose levels and proper hand hygiene after resident contact and glove use. This had the potential to affect all 79 residents residing in the facility. The census was 79. Findings included: 1. Review of the COVID-19 tracking log revealed Resident #43, Resident #61, Resident #73, Resident #75, Resident #137, and Resident #236 tested positive for COVID-19 in January 2025, Resident #65 and Resident #68 tested positive for COVID-19 in February 2025, and Resident #237, Resident #238, and Resident #239 tested positive for COVID-19 in March 2025. Review of the infection control logs dated January, February, and March 2025 revealed no documented tracking and/or testing related to COVID-19 and test results for Resident #43, Resident #61, Resident #73, Resident #75, Resident #137, Resident #236, Resident #237, Resident #238, and Resident #239. Interview on 06/05/25 at 3:24 P.M. with the Director of Nursing (DON) revealed she was currently the Infection Control Preventionist (ICP) and there were no current cases of COVID-19 and the last known positive result was in March 2025. The DON revealed the Administrator was responsible for maintaining and tracking the COVID-19 line list. The DON revealed she completed the infection control log at the end of every month for the previous months results and all infections were tracked and listed on the line list and infection control log. The DON revealed without accurate tracking and documentation, facility staff, residents, and visitors were unable to ensure care and services to prevent the spread of COVID-19. The DON confirmed and verified, after review with state surveyor, the COVID-19 line list and infection control logs for January, February, and March 2025 did contain Resident #43, Resident #61, Resident #73, Resident #75, Resident #137, Resident #236, Resident #237, Resident #238, and Resident #239's COVID-19 infections for those months. Review of the Centers for Disease Control and Prevention (CDC) document titled, Infection Control Guidance: SARS-CoV-2, dated 06/24/24, revealed healthcare settings should establish a process to identify and manage individuals with suspected or confirmed COVID-19 infection to prevent transmission to others. Review of the document revealed the facility did not implement infection control practices in the facility to decrease the spread of COVID-19.2. Review of the medical record for Resident #38 revealed an admission date of 04/11/25. Diagnoses included atherosclerotic heart disease and type II diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #38 had impaired cognition. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 06/03/25 at 8:29 A.M. revealed Registered Nurse (RN) #766 did not perform hand hygiene and gathered supplies to perform a blood sugar test with glucometer. RN #766 applied gloves without performing hand hygiene and entered Resident #38's room and placed the glucometer, lancet, test strips, and alcohol pads on the over bed tray on top of multiple magazines without using a barrier. RN #766 used Resident #38's left hand middle finger to obtain blood for the blood sugar reading. RN #766 then removed her gloves and applied new gloves without performing hand hygiene. Interview on 06/03/25 at 8:40 A.M. with RN #766 verified she did not perform hand hygiene before and after before and after glove usage and she did not use a barrier for the glucometer testing and supplies as she should have. Interview on 06/03/25 at 2:14 P.M. with the Director of Nursing (DON) verified hand hygiene was to be performed before and after glove usage and a barrier was to be placed for glucometer and supplies. Review of facility policy titled, Handwashing/Hand Hygiene, revised August 2019, revealed all personnel shall be trained on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. Use an alcohol-based hand rub or soap and water before and after direct contact with residents, before and after preparing or handling medications, before donning gloves, and after removing gloves. Review of facility policy titled, Infection Control Guidelines for All Nursing Procedures, revised August 2019, revealed employees must wash their hands for ten (10) to fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water before and after direct contact with residents, and after removing gloves. In most situations, the preferred method of hand hygiene was with an alcohol-based hand rub for the following situations: before and after direct contact with residents, before preparing or handling medications, after contact with objects such as medical equipment (glucometer), and after removing gloves. Review of facility policy titled, Obtaining a Fingerstick Glucose Level, revised October 2011, revealed the steps in the procedure included to use a disposable cloth (paper towel was adequate) to establish a clean field on the resident's bedside table to overbed table. Place the equipment on the clean field and arrange the supplies so that they can be easily reached. Perform hand asepsis by either washing hands with soap and water or using alcohol-based hand sanitizer, don clean gloves, and remove gloves and perform hand asepsis. This deficiency represents non-compliance investigated under Complaint Number OH00163749.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and staff interview, the facility failed to ensure its dryers were free from excessive lint build up. This had the potential to affect all 79 residents. The facility census was 79. Findings include: Observation of the laundry room on 06/09/25 at 4:22 P.M. revealed two of two dryers had a thick layer of lint built up in the lint traps that appeared to be significantly more than one dryer loads worth of lint. Interview on 06/09/25, at the time of the observation, with Housekeeping Director (HD) #799 revealed both dryers had not been cleaned and confirmed and verified the lint build up.

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F 0947 Level of Harm - Potential for minimal 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 review of personnel records and staff interview, the facility failed to ensure its certified nurse aides (CNAs) received 12 hours of in-service training per year as required. This had the potential to affect all 79 residents. The facility census was 79. Findings Include: 1. Review of the personnel record for CNA #713 revealed a hire date of 05/01/24. Review of in-service records from 05/01/24 through 05/01/25 revealed CNA #713 received 4.5 hours of in-service training all of which took place in the year 2025. 2. Review of the personnel record for CNA #740 revealed a hire date of 04/08/24. Review of in-service records from 04/08/24 through 04/08/25 revealed CNA #740 received 4.5 hours of in-service training all of which took place in the year 2025. Interview with the Administrator on 06/09/25 at 2:00 P.M. verified the lack of required in-services hours for CNA #713 and CNA #470. The Administrator further noted the facility had no evidence of education of in-services for CNAs prior to the year 2025.