

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365859	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER The Merriman		STREET ADDRESS, CITY, STATE, ZIP CODE 209 Merriman Rd Akron, OH 44303	
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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, and policy review, the facility failed to ensure residents received timely incontinence care. This resulted in Actual Harm on 07/13/26 when Resident #6 was incontinent of urine and bowel and required staff dependence for toileting and hygiene services, went approximately 12 hours without receiving incontinence care and developed two wounds on her buttocks. This affected one resident (Resident #6) of three reviewed for incontinence. The facility census was 48. Findings Include: Review of the medical record for Resident #6 revealed an admission date 02/21/26. Diagnoses included malignant neoplasm of the unspecified part of right bronchus or lung, hypertensive heart disease with heart failure, and chronic pain and was receiving hospice services. Resident #6 was her own responsible party. Review of Resident #6's physician orders dated 02/22/26 was to apply house barrier cream topically to groin, bilateral buttocks or other needed areas with episodes of incontinence for skin prevention. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 was moderately cognitive impairment. She was always incontinent of bowels and bladder and utilized a wheelchair. Review of the Functional Abilities assessment dated [DATE] revealed Resident #6 was dependent upon staff for toilet hygiene and toilet transfers. Review of the care plan dated 03/19/26 revealed Resident #6 was at risk and had an activity of daily living (ADL) self-performance deficit related to conditioning and weakness with disease progression and it noted an ADL decline was expected. Interventions for toileting hygiene stated the resident was able to perform toileting hygiene but required partial to moderate assistance. Resident #6 was able to complete personal hygiene but required substantial to maximal assistance. Review of the Point of Care documentation under tasks revealed the last documented evidence that incontinence care was completed for Resident #6 was on 07/12/26 at 9:37 P.M. Review of Resident #6's behavior documentation revealed from 07/02/26 through 07/15/26 she had no behaviors documented, including refusals of care. During an observation on 07/13/26 at 10:49 A.M., Resident #6 was up in her power wheelchair. Her incontinence pad was lying on her bed and was soiled with dry feces. Resident #6 was tearful. There was a strong odor of urine and feces in her room. During an interview on 07/13/26 at 10:49 A.M., Resident #6 tearfully explained that no one would change her. When she asked, they ignored her or told her that her aide was coming, but they would not come in. She said she felt like her bottom was broke with a rash that was killing me. She said she had been in the same incontinence brief for 12 hours. During an observation on 07/13/26 at 11:10 A.M., Certified Nursing Assistant (CNA) #385 asked Resident #6 if she had a bowel movement. He assisted her onto bed and laid her on her on the visibly soiled incontinence pad. When he removed Resident #6's incontinence brief, it was full of urine and feces. Resident #6 said at that time her buttocks were very sore and she felt like they were open. Upon observation she had two open wounds on her left buttocks that were pink in color with the first layer of skin removed. The areas appeared round and (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 0684 Level of Harm - Actual harm Residents Affected - Few	half the size of a dime.During an interview on 07/13/26 at 11:28 A.M., CNA #385 stated he was assigned to the hall Resident #6 was on. He usually waited for her to call for him before he went in. His shift started at 7:00 A.M. and this was the first time he checked on Resident #6 this day. He verified the soiled incontinence pad that smelled of urine was in the room and verified the heavily soiled incontinence brief.During an interview on 07/13/26 at 11:40 A.M., Licensure Practical Nurse (LPN) #250 verified the odor of urine in Resident #6's room. The new skin area was reported to LPN #250 at this time. She said she would assess the area. She said it was her expectation that staff should check Resident #6 for incontinence every two hours.Review of Resident #6's medical record revealed no documented evidence that a comprehensive initial wound assessment of the buttocks wound was completed on 07/13/26.Review of the progress notes revealed a late entry dated 07/15/26 at 10:19 A.M. by LPN # 250 that documented Resident #6 had superficial discoloration and chaffing to her inner bilateral buttocks. Incontinence cream was applied to the area. A message was left with hospice services, the wound nurse was notified and the resident was aware. The progress notes revealed no documented evidence of the wound measurements, drainage information, or wound descriptions.During an interview on 07/15/26 at 10:11 A.M., Hospice Registered Nurse (RN) #400 revealed she recently requested a care conference with the facility related to concerns she had with the quality of care and treatment Resident #6 was receiving. Hospice RN #400 stated Resident #6 had concerns with not timely receiving incontinence care. Hospice RN #400 also stated she had been in several times to find the resident in soiled incontinence briefs. She has not seen many changes from the care conference regarding her care concerns. Hospice RN #400 stated Resident #6 had a slow decline and was now fully dependent on incontinence care. She stated she was not notified of the new area to the resident's left buttocks. She visited Resident #6 today but did not look at the area because she didn't know about it.During an interview on 07/15/26 at 11:35 A.M., Assistant Director of Nursing (ADON) #216 stated Resident #6's hospice nurse requested a care conference on 06/24/26. She stated she was present at the conference, and she verified that concerns related to timely incontinence care were brought up. At this time, Resident #6 had also requested that CNA #385 no longer provide care for her, and she was afraid to ask for help due to the way staff treated her at times. ADON #216 verified she did not document in the medical record that the care conference took place. She said social services usually did that, but they did not have someone in that position at the time of the meeting. ADON #216 stated she relayed all the information to the Director of Nursing (DON) in a text message. She was unsure if the DON addressed the concerns.During an interview on 07/16/26 at 9:03 A.M., LPN #401 stated she was the wound nurse for the facility. She was not made aware of the new skin area on Resident #6 until 07/15/26 and had not yet had a chance to assess it herself.During an interview on 07/20/26 at 11:30 A.M., the DON stated she denied ever being made aware of the concerns from Resident #6's care conference. She said Resident #6 should have been provided with incontinence care every two hours, which is best practice and confirmed documentation showed she went over 12 hours without receiving documented incontinence care resulting in wounds. Additionally, the DON confirmed that the facility did not document the assessment regarding the area until two days after it was found and the assessment of the wound was not documented comprehensively.Review of the facility policy titled, Activities of Daily Living (ADLS) last reviewed 04/28/25 revealed residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, grooming, and oral care), mobility (transfer and (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	ambulation, including walking), elimination (toileting, incontinence care), dining (meals and snacks), communication (speech, language, and any functional communication systems), and bed mobility (turning, repositioning in bed) which is encouraged to the resident at least every two hours or as requested by resident. It also noted that residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. This deficiency represents non-compliance investigated under Complaint Numbers 3054313, 3006983, 2961251 and 2740378.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, manufacturer guidelines, and facility policy review, the facility failed to ensure medications were securely stored and Tuberculin solution was dated when opened for use. This deficient practice had the potential to affect all residents residing in the facility. The facility census was 48. Findings Include: 1) Review of Resident #8's medical record revealed admission date 10/14/25 and hospitalization date 07/09/26 with diagnoses including but not limited to Alzheimer's Disease, type two diabetes, heart failure, high blood pressure, depression and anxiety. Review of Resident #8's Self-Administration of Medication assessment dated [DATE] revealed Resident #8 required assistance with medication administration and was not approved to be self-administering medications. Observation on 07/14/26 at 7:54 A.M. revealed Resident #8's room door was open with multiple over the counter medication containers including Imodium, Aspirin, and Iron and three prescription bottles with several pills in each container sitting on the dresser beside the bed. Resident #8 is currently hospitalized. Interview on 07/14/26 at 8:00 A.M. with Licensed Practical Nurse (LPN) #502 verified the multiple medication containers sitting on the dresser in Resident #8's room. LPN #502 stated Resident #8 doesn't take most of the medications observed in her room. Review of the facility's policy titled Medication Storage dated 03/2026 revealed all drugs and biologicals will be stored in locked compartments under proper temperature controls. 2) Observation on 07/14/26 at 11:14 A.M. revealed a vial of open Tubersol Tuberculin (TB) Solution in the door of the medication refrigerator. The vial was half full and was not in the original package and had no open date noted. Interview on 07/14/26 at 11:23 A.M. with LPN #250 verified the open vial of TB solution with no date and not in the original package. LPN #250 stated the vial should have been kept in the original package and should have been dated when opened to be used. Review of the manufacturer's guideline for Tubersol Tuberculin Solution revealed a vial of Tubersol which has been entered and in use for 30 days should be discarded.		

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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, staff interviews, and policy review, the facility did not ensure the kitchen and equipment were clean and sanitary. This had the potential to affect all residents. Facility census was 48. Findings include: Initial tour of the kitchen on 07/13/26 from 8:27 A.M. to 8:56 A.M. with Dietary Director #303 revealed the ice machine sanitation log was last completed on 06/16/26. Review of the temperature logs for the walk-in cooler and freezer revealed temperatures were last recorded on 06/30/26. Surveyor observed water pooling on the floor adjacent to the right side of the steam table which Dietary Supervisor #331 reported the water continued to pool on the floor even after mopping and believed the water came from the actual floor and not a floor drain. A dark substance that resembled mold was observed on the backsplash to on the left side of the three compartments sink as well as the wall behind the dishwasher which Dietary Supervisor #331 reported had been there for years. The floor under the dishwasher was visibly dirty with dirt and grime. Dietary Director #303 was unable to check the chemical sanitation level of the low temperature dishwasher due to not having test strips. All findings were verified by Dietary Director #303 and Dietary Supervisor #331 at the time of the observations. Observation on 07/14/26 at 8:40 A.M. revealed water pooled on the floor adjacent to the right side of the steam table. Dietary Director #303 located test strips to test the chemical sanitation levels in the dishwasher however the Hydrion Chloride test strips expired 07/01/26. Observation on 07/15/26 at 8:40 A.M. again revealed water pooled on the floor adjacent to the right side of the steam table. Interview and observation on 07/15/26 at 10:38 A.M with Corporate Maintenance Director #402 revealed estimate was obtained to repair the pooled water in the kitchen however it required digging up that area. No estimates were provided. When asked about the mold-like substance behind the dishwasher and on the backsplash Corporate Maintenance Director #402 reported it was dirt and not mold. Dining observation on 07/16/26 from 8:35 A.M. to 8:57 A.M. revealed residents were eating breakfast from Styrofoam to go containers. Interview on 07/16/26 at 9:01 A.M. with [NAME] #218 revealed the chemical sanitation in three compartment sink was not sanitizing dishes and was not being repaired until 07/22/26. Interview on 07/16/26 at 9:03 A.M. revealed Dietary Director #303 still had not obtained test strips for the dishwasher. Review of the Sanitation Policy dated 08/01/23 revealed the food service area should be maintained in a clean and sanitary manner and all kitchen, kitchen areas, and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects. Review of the Food Storage Policy dated 08/12/23 revealed the internal air temperature of the refrigerator and freezer must be checked and recorded twice daily and logged.		

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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 interview, the facility failed to maintain access to the exit door and failed to maintain access to the fire extinguisher and the fire pull station in the back hallway. This had the potential to affect all residents residing in the facility. The facility census was 48. Findings Include: Observation on 07/15/26 at 7:36 A.M. revealed in the back hallway, where rooms 17 to 22 were located, there were two beds stored end to end on the left side of the hallway up against the wall. A manual wheelchair was located at the end of the second bed directly in front of the exit door, the fire pull station and the fire extinguisher box. There was approximately two-foot distance from the end of the second bed to the exit door and the fire pull station and fire extinguisher box was to accessible. Interview on 07/15/26 at 7:45 A.M. with Registered Nurse (RN) #510 verified the two beds and the manual wheelchair were blocking the exit door, the fire pull station and the fire extinguisher box. RN #510 stated I would find away to get the residents out in cause of evacuation. Interview on 07/15/26 at 12:02 P.M. with Maintenance Director (MD) #252 verified the two beds were still blocking the exit door. There was no manual wheelchair blocking the fire pull station or the fire extinguisher box. The Maintenance Director #252 stated the staff know better than to block the exit doors with medical equipment. These beds were not here the day before; someone must have moved them out overnight. This deficiency represent noncompliance investigated under Complaint Numbers 3006766 and 2961251.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of census documentation, interview, observations, and policy review, the facility failed to ensure Resident #32's room was clean and homelike. Additionally, the facility failed to ensure reasonable care for the protection of the resident's property when Resident #11's dentures were lost during a room change. This affected two residents (#11 and #32) out of two residents reviewed for resident rights. Facility census was 48. Findings Include: 1. Record review revealed Resident #32 was admitted on [DATE] with diagnoses of chronic obstructive pulmonary disease, diabetes mellitus due to underlying condition with diabetic neuropathy, hyperlipidemia, and other seizures. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #32 was cognitively intact, used a walker or wheelchair for mobility, required moderate assistance with toileting hygiene, showers, dressing lower body, putting on/taking off footwear, personal hygiene, and supervision for all transfers. Interview on 07/20/26 from 10:45 A.M. with Housekeeping Director #246 revealed there were two housekeepers on weekdays and one housekeeper on weekends, so rooms were to be cleaned daily. Observation during the interview with Housekeeping Director #246 revealed Resident #32's room was infested with gnats, had two plastic containers that contained food residue which sat on top of the air conditioning unit, wet clothing stuffed under the left side of the air conditioning unit which Housekeeping Director #246 reported Resident #32 used to soak up leaking water from the unit, and an overflowing garbage bag of dirty laundry which sat on the floor next to the air conditioning unit. Housekeeping Director #246 confirmed the observations. Review of the Environmental Services Inspection Policy dated August 2025 revealed it was the facility's policy to regularly monitor environmental services to ensure the facility was maintained in a safe and sanitary manner and assessed on a regular basis. 2. Review of Resident #11's medical record reveal admission date 11/25/25 with diagnoses including but not limited to chronic obstructive pulmonary disease (COPD), cocaine use, and anxiety. Review of Resident #11's physician orders revealed a diet order dated 11/25/25 for a regular diet, regular texture, thin liquids. Review of Resident #11's census documentation dated 03/04/26 revealed Resident #11 had moved from room [ROOM NUMBER] to room [ROOM NUMBER]. Review of Resident #11's quarterly [NAME] Data Set (MDS) assessment dated [DATE] revealed Resident #11 had moderately impaired cognition with a brief interview of mental status (BIMS) score of 13 out of 15, and no use of dentures or oral pain were marked. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 07/14/26 at 2:39 P.M. revealed Resident #11 had no natural teeth or dentures. Interview on 07/14/26 at 2:40 P.M. with Resident #11 revealed during a room move in March 2026 the facility lost Resident #11's dentures. Resident #11 stated the facility was aware of the lost dentures. Resident #11 had a community dentist appointment on 06/06/26 for denture replacement requiring Resident #11 to pay for the replacement dentures. Resident #11 did not have the financial means to pay for the dentures. Interview on 07/14/26 at 3:30 P.M. with the Director of Nursing (DON) verified Resident #11's dentures were lost during the room move on 03/04/26 and the facility had not assisted Resident #11 in replacing the lost dentures. The DON stated Resident #11 had a dentist appointment scheduled for 07/15/26 for Resident #11 to begin the process of replacing the dentures and the facility would be paying for the replacement set of dentures. This deficiency represent noncompliance investigated under Complaint Numbers 3074566, 3054313, 3043947, 3006766, 2961251, 2747089, and 2740378.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure ice water was offered routinely and at the frequency of resident requests for Resident #6, #12, and #30. This affected three residents (#6, #12, and #30) out of three residents reviewed for hydration. The facility also failed to ensure Resident #64 had routine meal intakes documented. This affected one resident (#64) out of four residents reviewed for dietary services. The facility census was 48. Findings Include: 1. Record review revealed Resident #64 was admitted on [DATE] with diagnoses of type I diabetes mellitus with diabetic neuropathy, chronic kidney disease stage III, protein calorie malnutrition, and hyperlipidemia. Review of the care plan initiated on 01/11/26 revealed one of Resident #64's diabetes interventions included monitoring for compliance with diet and documenting any problems. Review of the nutrition intake record for May 2026 revealed no meal intake was recorded for breakfast, lunch, and dinner on 05/02/26, 05/03/26, 05/07/26, 05/08/26, 05/09/26, 05/23/26, 05/24/26, 05/25/26, 05/26/26, 05/28/26, 05/29/26, 05/30/26, and 05/31/26. Review of the nutrition intake record for June 2026 revealed no meal intake was recorded for breakfast, lunch, and dinner on 06/01/26, 06/02/26, and 06/03/26. Interview on 07/16/26 at 3:40 P.M. with Regional Director of Clinical Operations #450 confirmed that meals were not recorded on the aforementioned dates. 2. Review of the medical record for Resident #6 revealed an admission date of 02/21/26. Diagnoses included but were not limited to malignant neoplasm of the unspecified part of right bronchus or lung, hypertensive heart disease with heart failure, and chronic pain. Review of Resident #6's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. The resident utilized a motorized wheelchair for mobility. Review of Resident #6's 06/29/26 care plan revealed she had an increased risk for constipation related to medication side effects. An intervention included to encourage the resident to drink fluids. The resident also had a care plan stating the resident was at risk for bowel and bladder incontinence, skin impairment and infection with an intervention to encourage fluids during the day to promote prompted voiding responses. Review of Resident #6's fluid intakes recorded in the plan of care documentation revealed from 07/08/26 until 07/15/26, the resident received 240 to 260 milliliters of fluid a day. Observation on 07/13/26 at 10:49 A.M. revealed an empty Styrofoam cup in Resident #6's room dated 07/11/26. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 07/13/26 at 10:49 A.M. with Resident #6 stated the facility did not pass fresh water or ice. She stated she had to request it and sometimes it came and sometimes it didn't. Interview on 07/13/26 at 11:28 A.M. with Certified Nursing Assistant (CNA) #385 confirmed the empty Styrofoam cup in Resident #6's room dated 07/11/26. 3. Review of the medical record for Resident #12 revealed an admission date of 02/21/26. Diagnoses included but were not limited to diabetes mellitus type two, psychoactive substance abuse, chronic idiopathic constipation, anxiety disorder, fibromyalgia, bipolar disorder, and abnormalities of gait and mobility. Review of Resident 12's quarterly Minimum Data Set (MDS) revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact. Review of Resident #12's care plan dated 06/09/26 revealed the resident had a history of occasional bowel and bladder incontinence with an intervention to encourage fluids during the day to promote prompted voiding responses. The resident was noted to also have an increased risk for constipation related to decreased mobility and a history of constipation with an intervention to encourage the resident to drink fluids. Interview on 07/13/26 at 2:29 P.M. with Resident #12 revealed staff did not offer or pass water to the residents. They were required to get it themselves. She revealed that yesterday (07/12/26) she asked Dietary Aide (DA) #325 for a cup of water and she said why the [expletive] are you knocking on this door. Don't knock [expletive] on this door and refused to give her water. Interview on 07/15/26 at 2:37 P.M. with [NAME] #319 revealed on 07/12/26, they were short staffed for dinner, and it was just him and DA #325 working. He stated DA #325 was yelling and was really upset. He told her to get ahold of herself, but she couldn't. She was yelling at the residents. He verified he did not see her obtain water for Resident #12. 4. Review of Resident #30's medical record revealed admission date of 06/11/24 with diagnoses including but not limited to chronic obstructive pulmonary disease (COPD), type two diabetes, and depression. Review of Resident #30's physician orders revealed an order dated 03/13/25 for increasing oral water intake up to 6 to 8 cups per day. Review of Resident #30's quarterly minimum data set (MDS) assessment dated [DATE] revealed Resident #30 had intact cognition with a brief interview mental status (BIMS) score of 13 out of 15, the resident had no difficulty with swallowing or choking and used a wheelchair for mobility. Observation on 07/14/26 at 10:33 A.M. revealed the utility room had a sign on the utility door reading, Staff Only. The room contained a cart with an empty ice chest and beside the ice chest there was a medium sized insulated water cooler half-filled with ice. Further observations on 07/13/26 and 07/14/26 revealed the cart was never outside the utility room with staff passing fresh ice and water. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365859	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER The Merriman		STREET ADDRESS, CITY, STATE, ZIP CODE 209 Merriman Rd Akron, OH 44303	
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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 07/14/26 at 10:41 A.M. revealed a half-filled Styrofoam cup of warm water sitting on Resident #30's bedside table dated 07/13/26 at 7:00 P.M. Interview on 07/14/26 at 11:00 A.M. with Registered Nurse (RN) #510 verified the half-filled Styrofoam cup of warm water sitting on Resident #30's bedside table. RN #510 stated night shift changed out the cups and filled them with fresh ice water. RN #510 stated it looked like she hasn't gotten any fresh ice water since last night. Interview on 07/14/26 at 4:08 P.M. with Certified Nursing Assistant (CNA) #385 verified the facility did not pass fresh ice water during shifts because the residents that were mobile came to the nurse's desk and asked for fresh ice water. Interview on 07/15/26 at 9:11 A.M. with the Director of Nursing (DON) stated her expectation was for staff to pass ice water each shift. She stated staff should be passing the ice water and not waiting for residents to ask. Review of the facility's policy titled Hydration/Fresh Water and Fluids dated 01/2020 revealed CNAs will provide fresh ice water to residents each shift. This deficiency represents non-compliance investigated under Master Complaint Number 3104157 and Complaint Numbers 3074566, 3054313, 3006766, 3006983, and 2740378.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, medical record review, and policy review, the facility failed to ensure residents had the right to a dignified existence and self-determination, when care concerns were not documented and appropriately addressed. This affected one out resident (#6) out of one resident reviewed for care conferences. Additionally, the facility failed to ensure Resident #15 received breakfast daily. This affected one (#15) of three residents reviewed for meals. The facility census was 48. Findings include: 1. Record review revealed Resident #15 was admitted [DATE] with diagnoses of end stage renal disease, chronic obstructive pulmonary disease, cirrhosis of liver, heart failure, and ventricular fibrillation. Review of the physician orders revealed Resident #15 had dialysis on Monday, Wednesday, and Friday with a pickup time of 6:30 A.M. Interviews with Resident #15 on 07/13/26 at 1:33 P.M. and 07/20/26 at 2:37 P.M. revealed she did not receive breakfast before dialysis on 07/13/26, 07/17/26, and 07/20/26. Interview on 07/14/26 at 8:51 A.M. with Dietary Supervisor #331 revealed she was unaware Resident #13 went to dialysis because no one informed her. Dietary Supervisor #331 reported she sent breakfast trays at the regular scheduled time and confirmed it was not before dialysis. Interview on 07/20/26 at 2:40 P.M. with Dietary Director #303 confirmed Resident #13 did not receive a breakfast tray before dialysis on 07/17/26. Interview on 07/20/26 3:23 P.M. with Dietary Director #303 confirmed Resident #13 did not receive a breakfast tray the morning of 07/20/26. Dietary Director #303 explained that kitchen staff prepared it however the aides never picked it up. Kitchen staff were advised to deliver the tray to Resident #13 if no one picked it up moving forward. Review of the Meal and Snack Hours and Frequency Policy dated 08/15/1923 revealed the facility provided three meals daily at regular times comparable to normal mealtimes in the community. 2. Review of the medical record for Resident #6 revealed an admission date of 02/21/26. Diagnoses included but were not limited to malignant neoplasm of the unspecified part of right bronchus or lung, hypertensive heart disease with heart failure, and chronic pain. Review of Resident #6's care plan dated 03/19/26 revealed the resident was at risk and had an activity of daily living (ADL) self-performance deficit related to conditioning and weakness with disease progression. It noted the ADL decline was expected. Interventions for toileting hygiene stated the resident was able to perform toileting hygiene but required partial to moderate assistance and the resident was able to complete personal hygiene but required substantial to maximal assistance. Review of Resident #6's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIM) score of 12 indicating moderate cognitive impairment. The MDS assessment also revealed the resident was always incontinent of bowel and bladder and utilized a wheelchair. Review of Resident #6's Functional Abilities assessment dated [DATE] revealed the resident was dependent for toileting hygiene and dependent for toilet transfers. Review of Resident #6's weekly wound assessment dated [DATE] revealed the resident had a left lateral leg trauma with a length of 7 centimeters (cm) width of 3.5 cm and a depth of 0.1 cm. The wound was noted to be declining. Review of the Point of Care documentation under tasks revealed the last documented evidence that incontinence care was completed for Resident #6 was on 07/12/26 at 9:37 P.M. During an observation on 07/13/26 at 10:49 A.M., Resident #6 was up in her power wheelchair. Her incontinence pad was lying on her bed and was soiled with dry feces. Resident #6 was tearful. There was a strong odor of urine and feces in her room. During an interview on 07/13/26 at 10:49 A.M., Resident #6 tearfully explained that no one would change her. When she asked, they ignored her or (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	told her that her aide was coming, but they would not come in. She said she felt like her bottom was broke with a rash that was killing me. She said she had been in the same incontinence brief for 12 hours. During an observation on 07/13/26 at 11:10 A.M., Certified Nursing Assistant (CNA) #385 asked Resident #6 if she had a bowel movement. He assisted her onto bed and laid her on her on the visibly soiled incontinence pad. When he removed Resident #6's incontinence brief, it was full of urine and feces. Resident #6 said at that time her buttocks were very sore and she felt like they were open. Upon observation she had two open wounds on her left buttocks that were pink in color with the first layer of skin removed. The areas appeared round and half the size of a dime. During an interview on 07/13/26 at 11:28 A.M., CNA #385 stated he was assigned to the hall Resident #6 was on. He usually waited for her to call for him before he went in. His shift started at 7:00 A.M. and this was the first time he checked on Resident #6 this day. He verified the soiled incontinence pad that smelled of urine was in the room and verified the heavily soiled incontinence brief. During an interview on 07/16/26 at 9:03 A.M., LPN #401 stated she was the wound nurse for the facility. She verified that she did not believe wound care was being completed as ordered for the resident. She stated she would find bandages on the resident that were dated several days prior. She stated the nurses were documenting in the treatment record that they were completing the treatment, but they were not. During an interview on 07/15/26 at 10:11 A.M. with Hospice Registered Nurse (RN) #400 revealed she recently requested a care conference with the facility related to concerns she had with the quality of care and treatment Resident #6 was receiving. Hospice RN #400 stated Resident #6 had concerns with not timely receiving incontinence care and wound care. Hospice RN #400 also stated she had been in several times to find the resident in soiled incontinence briefs. She went on to say she had not seen many changes from the care conference regarding her care concerns. During an interview on 07/15/26 at 11:35 A.M., Assistant Director of Nursing (ADON) #216 stated Resident #6's hospice nurse requested a care conference on 06/24/26. She stated she was present at the conference, and she verified that concerns related to timely incontinence care were brought up. At this time, Resident #6 had also requested that CNA #385 no longer provide care for her, and she was afraid to ask for help due to the way staff treated her at times. ADON #216 confirmed CNA #385 had previously been told to work a different hall, but ADON #216 didn't realize he was still taking care of Resident #6. She verified CNA #385 was caring for and completed incontinence care for Resident #6 on 07/13/26. ADON #216 also verified she did not document in the medical record that the care conference took place. She said social services usually did that, but they did not have someone in that position at the time of the meeting. ADON #216 stated she relayed all the information to the Director of Nursing (DON) in a text message. She was unsure if the DON addressed the concerns. Continued review of Resident #6's medical record revealed no evidence that the facility held a care conference or documented the concerns or resolution attempts from her care conference meeting. Interview on 07/20/26 at 11:30 A.M. with the DON denied ever being made aware of the concerns from Resident #6's care conference and therefore had not addressed the issues discussed. This deficiency represents noncompliance investigated under Complaint Numbers 3054313 and 2740226.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of facility self reported incidents, review of witness statements, and policy review, the facility failed to ensure Resident #12 was free from verbal abuse. This affected one resident (#12) out of five residents reviewed for abuse. The facility census was 48. Findings Include: Review of the medical record for Resident #12 revealed an admission date of 02/21/26. Diagnoses included but were not limited to diabetes mellitus type two, psychoactive substance abuse, chronic idiopathic constipation, anxiety disorder, fibromyalgia, bipolar disorder, and abnormalities of gait and mobility. Review of Resident #12's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact. Interview on 07/13/26 at 2:29 P.M. with Resident #12 revealed that yesterday (07/12/26) she asked Dietary Aide (DA) #325 for a cup of water and she said why the [expletive] are you knocking on this door. Don't knock [expletive] on this door and refused to give her water. She felt like the interaction was verbally abusive to her. She stated she reported it to Dietary Director #323 who stated she was going to look into it. She stated she made the report this morning after breakfast. Interview on 07/13/26 at 2:40 P.M. with Dietary Director #323 revealed Resident #12 came to her around 8:00 A.M. and stated DA #325 cursed at her. Dietary Director #323 told the resident she would follow up with her, but she had not had a chance to yet. Interview on 07/13/26 at 2:49 P.M. with the Administrator revealed Dietary Director #323 just now reported the incident, and she would complete an investigation and suspend DA #325 who was not at work today. Review of the Self-Reported Incident #276901 dated 07/13/26 and timed 3:38 P.M. revealed on 07/13/26, at around 11:45 A.M., Dietary Director #323 and the Director of Nursing (DON) notified this writer (the Administrator) that Resident #12 verbalized to them that on the weekend of 07/11/26 and 07/12/26, when she went to the kitchen to get water and a sandwich, the dietary aide [DA #325] swore at her and refused to accommodate her request. The investigation noted Not a single employee reported concerns regarding rude behavior or denying resident food or water, and the allegation of verbal abuse was unsubstantiated. Review of [NAME] #319's witness statement dated 07/13/26 revealed the kitchen was understaffed and they were overwhelmed. He noted DA #325 was cursing and slamming things. He kept trying to get her to calm down and nothing was working. At one point she went into the kitchen and told him that Resident #12 was talking about writing a bad review on the facility. [NAME] #319 asked Resident #12 what was wrong and she said she didn't give a [expletive]. He asked her if she was complaining about the food and if he could fix something else for her. She said she didn't know, but DA #325 was definitely cursing and conducting herself out of line. Interview on 07/15/26 at 2:37 P.M. with [NAME] #319 revealed on 07/12/26, they were short staffed for dinner, and it was just him and DA #325 working. He stated DA #325 was yelling and was really upset. He told her to get ahold of herself, but she couldn't. He stated she was yelling at the residents, he heard her yell Go away [racial slur] twice. He also heard her yelling [expletive] these mother [expletive]. He verified he knew the residents heard her and felt like she was being verbally abusive to them the way she was screaming and yelling. He went on to say she had a temper but, on this day, it was the worst he had ever seen. He also verified he did not see her obtain water for Resident #12. Follow up interview and observation on 07/15/26 at 3:29 P.M. with Resident #12 revealed on 07/12/26 she heard DA #325 say things like you all [racial slur] need to stop asking for [expletive] and you all [racial slur] get on my nerves, and I'm only here to collect unemployment. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #12 was observed as an African American. Interview on 07/22/26 at 9:12 A.M. with the Administrator revealed DA #325 was also African American. Review of the facility's policy, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property dated 10/2025 revealed residents have the right to be free from abuse, neglect, exploitation, and misappropriation of resident property. It is the facility's policy to investigate all alleged violations involving Abuse, Neglect, Misappropriation of Resident Property, Exploitation or Mistreatment, including Injuries of Unknown Source, in accordance with this policy and to ensure that all individuals who report such incidents and allegations are free from retaliation or reprisal for reporting the incident. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse and mental abuse, including abuse facilitated or enabled through the use of technology, such as through the use of photographs and recording devices to demean or humiliate a resident. This deficiency represents non-compliance investigated under Complaint Numbers 3006766 and 3006983.		

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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 observation, interview, record review, review of Self-Reported Incidents, review of witness statements, and policy review, the facility failed to ensure an allegation of abuse was reported timely. This affected one resident (#12) out of five residents reviewed for abuse. The facility census was 48. Findings Include: Review of the medical record for Resident #12 revealed an admission date of 02/21/26. Diagnoses included but were not limited to diabetes mellitus type two, psychoactive substance abuse, chronic idiopathic constipation, anxiety disorder, fibromyalgia, bipolar disorder, and abnormalities of gait and mobility. Review of Resident #12's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact. Interview on 07/13/26 at 2:29 P.M. with Resident #12 revealed that yesterday (07/12/26) she asked Dietary Aide (DA) #325 for a cup of water and she said why the [expletive] are you knocking on this door. Don't knock [expletive] on this door and refused to give her water. She felt like the interaction was verbally abusive to her. She stated she reported it to Dietary Director #323 who stated she was going to look into it. She stated she made the report this morning after breakfast. Interview on 07/13/26 at 2:40 P.M. with Dietary Director #323 revealed Resident #12 came to her around 8:00 A.M. and stated DA #325 cursed at her. Dietary Director #323 told the resident she would follow up with her, but she had not had a chance to yet. Interview on 07/13/26 at 2:49 P.M. with the Administrator revealed Dietary Director #323 just now reported the incident, and she would complete an investigation and suspend DA #325 who was not at work today. Review of the Self-Reported Incident #276901 dated 07/13/26 and timed 3:38 P.M. revealed on 07/13/26, at around 11:45 A.M., Dietary Director #323 and the Director of Nursing (DON) notified this writer (the Administrator) that Resident #12 verbalized to them that on the weekend of 07/11/26 and 07/12/26, when she went to the kitchen to get water and a sandwich, the dietary aide [DA #325] swore at her and refused to accommodate her request. The investigation noted Not a single employee reported concerns regarding rude behavior or denying resident food or water, and the allegation of verbal abuse was unsubstantiated. Review of [NAME] #319's witness statement dated 07/13/26 revealed the kitchen was understaffed and they were overwhelmed. He noted DA #325 was cursing and slamming things. He kept trying to get her to calm down and nothing was working. At one point she went into the kitchen and told him that Resident #12 was talking about writing a bad review on the facility. [NAME] #319 asked Resident #12 what was wrong and she said she didn't give a [expletive]. He asked her if she was complaining about the food and if he could fix something else for her. She said she didn't know, but DA #325 was definitely cursing and conducting herself out of line. Interview on 07/15/26 at 2:37 P.M. with [NAME] #319 revealed on 07/12/26, they were short staffed for dinner, and it was just him and DA #325 working. He stated DA #325 was yelling and was really upset. He told her to get ahold of herself, but she couldn't. He stated she was yelling at the residents, he heard her yell Go away [racial slur] twice. He also heard her yelling [expletive] these mother [expletive]. He verified he knew the residents heard her and felt like she was being verbally abusive to them the way she was screaming and yelling. He went on to say she had a temper but, on this day, it was the worst he had ever seen. He also verified he did not see her obtain water for Resident #12. [NAME] #319 verified he did not report the incident even though he felt like DA #325 was being verbally abusive to the residents. Follow up interview and observation on 07/15/26 at 3:29 P.M. with Resident #12 revealed on 07/12/26 she heard DA #325 say things like you all [racial slur] (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	need to stop asking for [expletive] and you all [racial slur] get on my nerves, and I'm only here to collect unemployment. Resident #12 was observed as an African American. Interview on 07/20/26 at 11:20 A.M. with the Administrator revealed all allegations of abuse, including verbal abuse, should be reported to her right away. She verified this was not done. Review of the facility's policy, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property dated 10/2025 revealed residents have the right to be free from abuse, neglect, exploitation, and misappropriation of resident property. All incidents and allegations of Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of resident property and all Injuries of Unknown Source must be reported immediately to the Administrator or designee. The Administrator/designee should be notified by informing him/her in person, calling via telephone, or sending an email or text message. This deficiency represents non-compliance investigated under Complaint Numbers 3006766 and 3006983.		

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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, observation, interview, and facility policy review, the facility failed to assess and implement smoking safety for residents. This deficient practice affected one resident (Resident #16) out of two residents reviewed for smoking safety. The facility census was 48. Findings Include: Review of Resident #16's medical record revealed admission date of 05/29/26 with diagnoses including pleural effusion, chronic obstructive pulmonary disease (COPD), high blood pressure, heart failure and cellulitis of lower leg. Review of Resident #16's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 had moderately impaired cognition with a brief interview of mental status (BIMS) score of 10 out of 15 and used a wheelchair for mobility. Review of Resident #16's smoking safety assessment dated [DATE] revealed Resident #16 was assessed as a non-smoker. Review of Resident #16's care plan revealed no smoking care plan implemented until 07/14/26. Observation on 07/13/26 at 1:37 P.M. revealed Resident #16 was self-propelling himself in a wheelchair in the hallway going towards the resident smoking area. Resident #16 had a lighter and a half-burned cigarette in his hand. Observation on 07/13/26 at 2:01 P.M. revealed in Resident #16's room revealed a half-burned cigarette on the floor by the dresser and a half-burned cigarette on the floor under the bed. There was also a lighter on the floor under the bed. Review of Resident #16's updated care plan dated 07/14/26 revealed Resident #16 smoked cigarettes and verbalized adherence to the facility smoking policy, which included keeping smoking materials secured in his room. Interview on 07/14/26 at 4:12 P.M. with MDS Licensed Practical Nurse (LPN) #355 verified Resident #16's smoking assessment was inaccurate and the smoking care plan was implemented on 07/14/26. MDS LPN #355 stated every time the staff would interview Resident #16 for smoking safety, Resident #16 would state he was not a smoker. Review of the facility's policy titled Smoking revealed residents who are assessed and demonstrate the ability to smoke independently may keep smoking materials on their person while smoking or put away in their room.		

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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, interview, and facility policy review, the facility failed to ensure transportation was available for a dialysis dependent resident. This deficient practice affected one resident (#2) out of two residents reviewed for dialysis. The facility census was 48. Findings Include: Review of Resident #2's medical record revealed admission date of 10/30/25 with diagnoses including but not limited to end stage renal disease, renal dialysis, asthma, depression and type two diabetes. Review of Resident #2's quarterly minimum data set (MDS) assessment dated [DATE] revealed Resident #2 had moderately impaired cognition with a brief interview mental status (BIMS) score of 11 out of 15, he received dialysis and used a power wheelchair for mobility. Review of Resident #2's physician orders revealed an order dated 01/23/26 for transportation arriving Monday, Wednesday, Friday between 6:00 A.M. to 6:45 A.M. to [the dialysis] Center, to return at 11:15 A.M. with the resident back to facility via the [NAME] transportation van. Review of Resident #2's progress note dated 05/18/26 (Monday) at 9:09 A.M. revealed Resident #2 missed dialysis related to the transportation company having no driver for that day. Review of Resident #2's pre/post dialysis assessment listings revealed there were no pre/post dialysis assessments completed for Monday 05/18/26, Wednesday 05/20/26 or Friday 05/22/26 to review. Further review of Resident #2's medical record revealed no documented evidence of reasonable efforts to ensure the resident was able to receive dialysis services on 05/18/26, 05/20/26, and 05/22/26. Interview on 07/13/26 at 3:35 P.M. with Resident #2 revealed during the month of May 2026 he had missed dialysis treatments due to his insurance transportation not coming to transport him to dialysis and the dialysis center had called the facility checking on Resident #2 related to missing a week of dialysis treatments. Interview on 07/20/26 at 3:35 P.M. with the Director of Nursing (DON) verified Resident #2 did not receive dialysis treatments during the week of 05/18/26 to 05/22/26 due to having no transportation available. The DON stated Resident #2's insurance covered transportation and Resident #2 had used the covered transportation for the year. Review of the facility's policy titled Dialysis Transportation Contingency Policy revealed when scheduled insurance transportation does not arrive as planned, the facility will make reasonable efforts to ensure the resident receives treatment while maintaining resident safety, regulatory compliance, and appropriate documentation. This deficiency represents non-compliance investigated under Complaint Number 3021171.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365859	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER The Merriman		STREET ADDRESS, CITY, STATE, ZIP CODE 209 Merriman Rd Akron, OH 44303	
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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the timely reordering of Resident #28's antianxiety medication. This affected one out of one resident's review for behavioral health services. The facility census is 48. Review of the medical record for Resident #28 revealed an admission date of 10/22/25. Diagnoses included but were not limited to panic disorder, psychoactive substance use, major depressive disorder, chronic pain, and insomnia. Review of Resident #28's quarterly Minimum Data Set (MDS) dated [DATE] revealed the residents Brief Interview for Mental Status (BIMS) score of 15 which indicated that a resident's cognitive function is intact. Review of Resident #28's care plan dated 06/09/26 revealed the resident had an alteration in mood related to depression, panic disorder, and anxiety with an intervention to administer medications as ordered. Monitor and document for side effects and effectiveness. Review of Resident #28's orders revealed an order for Alprazolam (Xanax) 0.25mg by mouth three times a day related to panic disorder. The order was dated 12/27/25. Review of Resident #28's progress notes revealed on 07/12/26 at 10:04 P.M. the residents Xanax 0.25mg was pending from pharmacy, On 07/13/26 at 1:12 PM the medication was not available. On 07/17/26 at 1:56 P.M. the medication was awaiting a new script. On 07/19/26 at 4:53 P.M. awaiting arrival from pharmacy and at 4:53 P.M. stated medication is not on hand. Review of Resident #28's Medication Administration Record (MAR) dated July 2026 revealed the resident did not receive her scheduled dose of Xanax 0.25 mg twice on 07/12/26, three times on 07/13/26, once on 07/15/26, once on 07/17/26, and twice on 07/19/26. Resulting in nine missed doses. Observation on 07/13/26 at 4:06 P.M. Resident #28 was sitting outside in her wheelchair. She appeared upset. When approached she became tearful. Interview in 07/13/26 at 4:06 P.M. Resident #28 reported she has currently gone two days without her scheduled medication (Xanax 0.25mg). She tearfully reported she is experiencing a lot of anxiety. She stated the facility does not stay on top of ordering her medication and this is a frequent occurrence. Interview on 07/14/26 at 10:42 A.M. Licensed Practical Nurse (LPN) #345 reported she contacted the pharmacy on Saturday and asked for them to send the medication. She reported she did not work on Monday but does currently have the medication but has not administered it to Resident #28 yet this morning. Observation on 07/14/26 at 11:15 A.M. of the medication storage in the facility with LPN #250 revealed the facility has eight Xanax 0.25 mg available to be can be pulled. Interview with LPN #250 revealed ideally if a medication is out they can pull with two nurses as long as they have access and approval from pharmacy. She verified this was not completed. Interview on 07/14/26 at 3:18 P.M. Assistant Director of Nursing (ADON) #216 reported that Resident #28's prescription ran out of refills. She reviewed the record and the facility did not attempt to get a new prescription until 07/13/26. She verified the medication was available in the contingency box but the nurses did not pull the medication. Interview on 07/20/2026 at 11:29 A.M. the facility DON revealed the facility had not obtained timely refills or pulled the medication from the contingency resulting in Resident #28 missing several doses of her antianxiety medication. This deficiency represents non-compliance investigated under Complaint Numbers 3006983, 3006766, and 2740378.		

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to schedule ordered diagnostic tests for residents. This deficient practice affected one resident (#16) out of one resident reviewed for diagnostic testing. The facility census was 48. Findings Include: Review of Resident #16's medical record revealed an admission date of 05/29/26 with diagnoses including pleural effusion, Chronic Obstructive Pulmonary Disease (COPD), high blood pressure, heart failure and cellulitis of lower leg. Review of Resident #16's admission Minimum Data Set (MDS) dated [DATE] revealed Resident #16 had moderately impaired cognition. Review of Resident #16's physician orders revealed an order dated 07/01/26 for bilateral venous doppler and bilateral arterial doppler for lower legs. Review of Resident #16's diagnostic results revealed there were no results from the doppler diagnostic testing ordered on 07/01/26 to review. Interview on 07/16/26 at 10:53 A.M. with the Assistant Director of Nursing (ADON) verified Resident #16's bilateral venous doppler and bilateral arterial doppler for lower legs had not been scheduled by the facility. The ADON stated the expectations for the nurses are to review the written physician orders and schedule the ordered testing. This deficiency represents non-compliance investigated under Complaint Number 2740378.		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, interview, and record review, the facility failed to ensure Resident #12 was scheduled for a dental appointment as recommended after experiencing dental pain and a tooth infection. This affected one (#12) out of two residents reviewed for dental services. The facility census was 48. Review of the medical record for Resident #12 revealed an admission date 02/21/26. Diagnoses included but were not limited to diabetes mellitus type two, psychoactive substance abuse, chronic idiopathic constipation, anxiety disorder, fibromyalgia, bipolar disorder, and abnormalities of gait and mobility. Review of Resident 12's quarterly Minimum Data Set (MDS) revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact. Review of Resident #12's care plan dated 06/09/26 revealed she did not have a care plan related to her teeth or dental services. Review of Resident #12's treatment history report revealed her last dental exam was on 03/06/25. Review of Resident #12's progress note dated 04/24/26 created by Advanced Practice Registered Nurse #403 revealed the resident was being seen due to toothache and inflammation. The resident reported that it started a few days ago but has worsened. She has taken Tylenol for the pain but would also like something else. She had visible inflammation of the gum, and her tooth appeared in poor condition. Will order antibiotic and schedule an appointment with the dentist. Review of Resident #12's physician's orders revealed an order dated 04/24/26 for Amoxicillin (antibiotic) 500 milligram capsule to be taken by mouth twice daily for 10 days for a tooth infection. Observation on 07/13/26 at 2:27 P.M. of Resident #12 revealed two missing bottom front teeth. Interview on 07/13/2026 at 2:27 P.M. with Resident #12 revealed she had reported to the previous social worker that she needed to see a dentist due to issues with her teeth. She stated these issues included discomfort and missing teeth. She stated she has yet to see a dentist. Interview on 07/15/26 at 2:12 P.M. Resident #12 reported she had a partial denture at one point, but it has been missing and she also had a tooth on the top of her mouth that was recently infected that required an antibiotic. Interview on 07/15/26 at 12:11 P.M. Social Services Director #206 revealed she is unable to find evidence where Resident #12 was seen for a dental exam after her tooth infection. She reported she was last seen on 03/06/25. Interview on 07/15/26 at 4:09 P.M. the Director of Nursing (DON) verified Resident #12 was not assisted with making a dental visit after experiencing a tooth infection and tooth discomfort as recommended.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, interviews, and facility policy review, the facility failed to ensure infection control was maintained during transport of soiled linens and failed to ensure hand hygiene during incontinence care and Enhanced Barrier Precautions were implemented appropriately. This affected one resident (#16) out of one resident reviewed for wound care and affected one resident (#6) out of one resident reviewed for incontinence care. The facility census was 48. Findings Include: 1. Review of Resident #16's medical record revealed admission date of 05/29/26 with diagnoses including but not limited to cellulitis of lower leg, pleural effusion, high blood pressure, and heart failure. Review of Resident #16's physician orders revealed an order dated 07/02/26 for wound care to cleanse the right foot with normal saline or wound cleanser, apply Xerofoam, apply abdominal dressing and wrap with kerlix daily. There were no Enhanced Barrier Precautions (EBP) orders to review. a. Observation on 07/13/26 at 1:40 P.M. revealed Resident #16's room did not have EBP signage or Personal protective Equipment (PPE) available for the direct care of Resident #16. Interview on 07/16/26 at 9:13 A.M. with Licensed Practical Nurse (LPN) #345 stated Resident #16 was not on isolation or EBPs for his wounds. Interview on 07/16/26 at 10:23 A.M. with the Director of Nursing (DON) verified Resident #16 did not have EBP implemented. The DON stated the staff was to notify her of any residents with wounds and then EBPs would be implemented. b. Observation on 07/16/26 at 9:44 A.M. revealed the Assistant Director of Nursing (ADON) was completing the wound care to Resident #16's right lower leg and foot. The ADON removed her gloves and sanitized her hands. There were soiled bed linens on the floor by the door, the ADON picked up the pile of soiled bed linens with no gloves in place and carried the soiled linens to the dirty utility room and placed them in the soiled laundry cart. The ADON then left the soiled utility room without sanitizing or washing her hands. Interview on 07/16/26 at 9:55 A.M. with the ADON verified she had picked up the soiled bed linens without using gloves and transported them to the soiled utility room, placed them in the soiled laundry cart and left the room without sanitizing or washing her hands. The ADON stated she probably should have worn gloves and washed her hands afterwards. 2. Review of the medical record for Resident #6 revealed an admission date of 02/21/26. Diagnoses included but were not limited to malignant neoplasm of the unspecified part of right bronchus or lung, hypertensive heart disease with heart failure, chronic pain, and a leg wound. Review of Resident #6's July 2026 physician orders revealed an order dated 03/24/26 for Enhanced (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Barrier Precautions (EBP), due to a wound with instructions to be completed every shift. Review of Resident #6's the care plan dated 06/29/26 revealed the resident had a care plan related to EBP for wounds. Interventions included to keep EBP in place until wound was healed, notify resident/family/visitors/staff/volunteers of implementation of EBP, post a sign on door or wall outside the residents room to identify the need for EBP, supply gowns and gloves outside the residents room, and use gowns and gloves when providing high-contact resident care activities such as: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care/use/maintenance and wound care requiring dressings. Observation on 07/13/26 at 10:49 A.M., Resident #6 was up in her power wheelchair. Her incontinence pad was lying on her bed and was soiled with dry feces. Resident #6 was tearful. There was a strong odor of urine and feces in her room. Observation on 07/13/26 at 11:08 A.M. of the outside door to Resident #6's room revealed a sign posted to don personal protective equipment (PPE) related to EBP. A cart was next to the door with gowns and gloves. Observation on 07/13/26 at 11:10 A.M. revealed Certified Nursing Assistant (CNA) #385 entered Resident #6's room and asked the resident if she had a bowel movement. Without donning a gown or washing his hands, he applied gloves and assisted Resident #6 onto the bed and laid her on her on the dirty incontinence pad. When he removed Resident #6's incontinence brief, it was full of urine and feces. He completed the incontinence care using the same pair of gloves the whole time. After the care was completed, he removed the dirty pad, repositioned the resident, cleaned up, then removed his gloves and washed his hands. Interview on 07/13/26 at 11:28 A.M. with CNA #385 verified improper infection control practices and that he failed to don appropriate PPE prior to care. Review of the facility policy, Enhanced Barrier Precautions (EBP) dated 10/2025 revealed EBP refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of [NAME] to staff hands and clothing.		