

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

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365865	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2026
NAME OF PROVIDER OR SUPPLIER Main Street Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Community Drive Avon Lake, OH 44012	
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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident representative and staff interviews, record review, review of the National Pressure Injury Advisory Panel 2025 guidelines and review of facility policy, the facility failed to evaluate and identify risk factors and define and implement interventions to prevent avoidable pressure injuries. Additionally, the facility failed to initiate treatment timely to the newly identified avoidable pressure injury. Actual Harm occurred on 07/19/25 when Resident #125 developed an avoidable deep tissue injury (Purple or maroon area of discolored intact skin due to damage of underlying soft tissue.) to her right knee from an immobilizer that was not physician ordered or identified by the facility to be in place. This affected one (Resident #125) of three residents reviewed for wounds. The facility census was 113. Findings include: Review of Resident #125's medical record revealed an admission date of 01/14/25 and a discharge date of 02/20/26. Diagnoses included Alzheimer's Disease with late onset and dementia. Review of the care plan dated 01/15/25 and revised on 07/22/25 revealed Resident #125 had the potential for impairment of skin integrity including a history of deep tissue injury (DTI) to right buttock, history of moisture associated skin damage (MASD) to the buttocks, pressure injuries to the right and left heel, and history of area to the right knee. Goals included skin intervention/preventative measures to be maintained, and Resident #125 would have no avoidable skin breakdown. Interventions included minimizing pressure on bony prominences. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #125 had severe cognitive impairment and utilized a wheelchair. Resident #125 was dependent on staff for lower body dressing. Review of the progress note dated 07/07/25 revealed Resident #125 fell. Certified Nurse Practitioner (CNP) #430 was notified and a new order for a two-view x-ray to the right lower extremity and right hip was placed. The progress note dated 07/08/25 revealed Resident #125 complained of pain this morning (07/08/25) and advised Resident #125 would remain in bed and non-weight bearing (NWB) until x-ray results were known. Resident #125's right lower extremity was immobilized. The physician progress note dated 07/08/25 revealed Resident #125 had an acute hip fracture and to continue NWB status. There was no recommendation for an immobilizer to the right knee. Review of Resident #125's physician orders and progress notes dated 07/08/25 through 07/14/25 revealed there was no evidence a knee immobilizer was ordered. There was no evidence Resident #125 had a right knee immobilizer or if the skin was assessed in the right knee area. The physician progress note dated 07/09/25 at 10:09 A.M. revealed CNP #430 did not mention or recommend an immobilizer to the right knee. From 07/14/25 to 07/18/25, Resident #125 was in the hospital for right hip fracture with surgical repair. There were no recommendations for a right knee immobilizer. The progress note dated 07/18/25 revealed Resident #125 arrived at the facility from status post-surgical repair of the right hip. Resident #125 had a right knee abrasion measuring 6.0 centimeters (cm) in length by 0.5 cm in width with no depth and staging was marked not applicable. There was no mention of a right immobilizer or pressure injury present on the right knee. The progress note dated 07/19/25 revealed Resident #125's daughter was questioning nursing about markings on her right knee from an immobilizer that was on Resident #125 when she went to the hospital on [DATE] from her ortho appointment. Resident #125's daughter mentioned that she had no knowledge (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 365865	Facility ID: 365865 If continuation sheet Page 1 of 15

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F 0686 Level of Harm - Actual harm Residents Affected - Few	but he did not remember a lot about the situation and was not sure why there was no order. WN #325 revealed Resident #125 was readmitted to the facility on [DATE] and was not seen by WNP #433 until 07/21/25. Review of the National Pressure Injury Advisory Panel 2025 guidelines for the International Guidelines for Prevention and Treatment of Pressure Ulcers/Injuries revealed regardless of age or clinical setting, a resident should be considered at risk for a pressure injury as soon as a medical device is applied. Further review of the guidelines revealed staff should frequently evaluate and where feasible, resize or reposition medical devices used in residents at risk. Continued review of the guidelines revealed the provider should develop standardized protocols for reducing the risk of device related pressure injuries based on the device type. Review of the facility policy titled Wound Prevention and Management Policy revised 10/2022 revealed it was the policy of the facility that, upon admission, all residents would have a comprehensive skin assessment to identify current skin breakdown and identify pressure ulcer risk factors. A preventative plan of care and intervention would be initiated for any residents determined to be at risk, to reduce the possibility of further breakdown. This deficiency represents non-compliance investigated under Complaint Number 2572317.		

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F 0689 Level of Harm - 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 resident representative and staff interviews, record review, policy review, and review of the National Institute for Health's National Library of Medicine (NIH) publications, the facility failed to ensure a resident who was at a high risk for falls was assessed for the cause of falls and ensure interventions were implemented to prevent additional falls. Actual Harm occurred on 04/10/25 when Resident #125 was found on the floor in her room and sustained a closed compression fracture of lumbar 3 (L3) vertebra. The facility stated the fall was related to orthostatic hypotension (sudden drop in blood pressure occurring when standing up from a sitting or lying position defined as a systolic drop of greater than or equal to 20 millimeters of mercury (mm Hg) or diastolic greater than or equal to 10 mm Hg within three minutes); however, there was no evidence the resident was assessed to have orthostatic hypotension. Resident #125 fell again on 05/10/25 with no injuries, 06/02/25 with no injuries, 06/04/25 went to the emergency room (ER) and received two staples on top of her head, 07/07/25 sustained a right hip fracture requiring surgery, and on 02/13/26 with multiple fractures including a closed fracture of multiple ribs to the left side, a closed fracture of left wrist, and a facial laceration requiring eight sutures. Resident #125 had purple ecchymosis (a large bruise caused by blood leaking from broken vessels into subcutaneous tissue) to the left cheek and red ecchymosis to the left shoulder and scattered ecchymosis to right upper extremity and bilateral lower extremities. Resident #125 passed away on 02/20/25 and the Death Certificate stated the manner of death was accident and the underlying cause was due to sequelae of blunt impacts to the head, trunk, and left arm with fractures and soft tissue injuries due to falls. This affected one (Resident #125) of three residents reviewed for falls. The facility census was 113. Findings include: Review of Resident #125's medical record revealed an admission date of 01/14/25 and a discharge date of 02/20/26. Diagnoses included Alzheimer's disease with late onset, paroxysmal atrial fibrillation, fracture of carpal bone of the left wrist, multiple fractures of the ribs on the left side, laceration of head, dementia, and anxiety disorder. Review of the care plan dated 01/15/25 revealed Resident #125 had a safety concern and the potential for falls, injury. Resident #125's safety would be maintained, and she would have minimal risk of injury and falls. An intervention on 01/15/25 included to encourage non-skid footwear at all times; an intervention on 04/10/25 included encourage Resident #125 to be in the common areas while awake; on 05/10/25 an intervention was initiated to encourage Resident #125 to lay in her recliner while she was in her room every shift; on 06/03/25 an intervention to place a reminder sign in Resident #125's room to remind her to use the call light for assistance; and on 02/13/26, an intervention to complete visual checks every 30 minutes for three days was initiated. The care plan dated 01/15/25 revealed Resident #125 had the potential for altered behavior patterns, disruptive interactions, agitation and/or anxiety. Resident #125 reached for objects not present and fidgeted in her chair. Resident #125 would be calm in a secure environment, and her safety would be maintained. Interventions included a fidget blanket starting on 02/17/26. Review of Resident #125's Falls Risk assessment dated [DATE] revealed Resident #125 was at a higher risk for falls. Review of Resident #125's progress notes dated 04/10/25 at 10:54 A.M. revealed the nurse was alerted by the housekeeper (unidentified) that Resident #125 was on the floor in her room. Resident #125 was found sitting on the floor. Resident #125 stated she heard voices in the hall and fell when she went to check on this. Resident #125 denied pain or discomfort and was able to move all extremities with no issues. Resident #125's vital signs were checked and the resident had orthostatic hypotension. (There was no evidence in the medical record of orthostatic hypotension at the time of the fall.) The physician ordered Resident #125 to be transported to the ER for evaluation. The progress note dated 04/10/25 revealed a follow up investigation that was completed for the fall, and the immediate intervention was orthostatic blood pressures. Other interventions were to encourage Resident #125 to be in the (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	common areas while awake and therapy screening for safety. The comprehensive fall investigation was not available to view including witness statements because they were quality assurance protected information (QAPI). The facility did not show the fall was investigated thoroughly, to ensure fall interventions were in place at the time of the fall, determine Resident #125's orthostatic blood pressure by obtaining vital signs, and determine the cause of the fall. Review of the After Visit Summary for a hospital stay from 04/10/25 through 04/12/25 revealed Resident #125 was admitted for a fall and proctitis (inflammation of the rectum's lining). Resident #125 had an unwitnessed fall and stated in the ER that her head, lower back and legs hurt. Resident #125 had a computed tomography (CT) scan of the abdomen and pelvis and a closed compression fracture of L3 vertebra was found. Resident #125 was admitted for observation to control her lumbar fracture pain and to monitor overnight for bright red blood per rectum and receive intravenous antibiotics for proctitis. Resident #125 improved and her symptoms resolved. Review of Resident #125's physician orders dated 04/13/25 revealed to always encourage non-skid footwear every shift. The fall plan of care revealed on 01/15/25, there was already an intervention for non-skid footwear. Review of Resident #125's physician orders dated 04/30/25 revealed single room isolation, and contact precautions for Clostridioides difficile (C. diff). The order was discontinued on 05/27/25. The progress note dated 05/10/25 at 9:01 P.M. revealed the nurse was called to the room due to Resident #125 was sitting on the floor in front of her wheelchair. It was reported that Resident #125 was very restless all day and trying to stand up by herself. Resident #125 had full range of motion with no skin concerns and no evidence of injury. The daughter requested that Resident #125 was put in her recliner more often with her legs elevated. The comprehensive fall investigation was not available to view including witness statements because they were QAPI. The facility did not show that the fall was investigated thoroughly, to ensure fall interventions were in place at the time of the fall including proper footwear, address Resident #25's restlessness, and determine the cause of the fall. The progress note dated 06/02/25 at 3:08 P.M. revealed Resident #125's daughter-in-law stated she was watching the camera and Resident #125 was walking around the room, sitting on the arm of the recliner then fell onto the floor. Resident #125's daughter-in-law called to notify the nurse that Resident #125 was on the floor. Resident #125's range of motion was within normal limits, neuro checks were initiated and no injury was noted. An intervention was to wear proper footwear or non-slip socks while out of bed. (The fall plan of care revealed on 01/15/25, there was already an intervention for non-skid footwear and on 04/13/25, there was a physician order for non-skid footwear.) The comprehensive fall investigation was not available to view because they were QAPI. The facility did not show the fall was investigated thoroughly, to ensure fall interventions were in place at the time of the fall including the previous fall intervention of non-skid footwear (care plan intervention on 01/15/25 and physician order on 04/13/25), determine the cause of the fall, and implement appropriate interventions which could have included staff education and/or discipline to ensure fall interventions were implemented. The progress note dated 06/04/25 at 8:43 A.M. revealed Resident #125 was found on the floor of her room lying on her right side next to the rollator (wheeled walker). Resident #125 had a gash to the top of her head, and a bruise was noted to her right wrist. Resident #125 was sent to the ER due to being on a blood thinner per an unidentified Certified Nurse Practitioner (CNP). A new intervention was to place Resident #125 on every 15-minute checks while on isolation precautions (Isolation precautions were discontinued on 05/27/25). The comprehensive fall investigation was not available to view including witness statements because they were QAPI. The facility did not show the fall was investigated thoroughly, to ensure fall interventions were in place at the time of the fall and determine the cause of the fall. The progress note dated 06/04/25 revealed Resident #125 returned from the ER with two staples on top of her head. Resident #125 denied pain or discomfort. The progress note dated 07/07/25 at 9:09 P.M. revealed while she was assisting another resident (unidentified) the nurse (unidentified) heard Resident #125 yelling for help. Resident #125 was leaning on the scheduler's door and sitting on the floor in front of her wheelchair. Resident #125 stated she was getting help to get up (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	with closed fracture of multiple ribs to the left side, closed fracture of left wrist, and a facial laceration with eight sutures in place and the area was draining a large amount of serosanguinous drainage. Resident #125 was to follow up with orthopedic. Resident #125 had purple ecchymosis to the left cheek and red ecchymosis to the left shoulder and scattered ecchymosis to right upper extremity and bilateral lower extremities. Resident #125 appeared to be anxious and in pain with facial grimacing, moaning and calling out. As needed anxiety and pain medication were provided with effect. Splint in place to left upper extremity. Resident #125's family was at the bedside. The comprehensive fall investigation was not available to view including witness statements because they were QAPI. The facility did not show the fall was investigated thoroughly, to ensure fall interventions were in place at the time of the fall, revealing how long Resident #125 was lying on the ground to determine adequate supervision and rule out neglect, and determine the cause of the fall. The progress notes dated 02/20/26 revealed at 2:21 A.M., Resident #125's skin was warm to touch, and she had an absence of vital signs and pupillary response and was pronounced by two nurses. Hospice services were notified. Review of the Certificate of Death dated 02/20/26 revealed Resident #125 had adult failure to thrive, and the manner of death was accident. The place of injury was the nursing home memory care unit dining area and the injury date and time were 02/13/26 at approximately 5:20 A.M. The underlying cause was due to sequelae of blunt impacts to the head, trunk, and left arm with fractures and soft tissue injuries due to falls. Other significant conditions contributing to the death but not resulting in underlying causes were dementia, recent hip fracture, atrial fibrillation, hypertension, chronic kidney disease, and osteoporosis. During an interview on 04/14/26 at 10:50 A.M., Power of Attorney (POA) #431 revealed Resident #125 experienced a broken hip in July 2025 and fell again on 02/13/26. POA #431 stated Resident #125 had fallen on her face first out of her padded wheelchair. Resident #125 had broken multiple ribs, had a broken arm, a broken wrist and had a huge laceration on the side of her face. POA #431 indicated Resident #125 passed away on 02/20/26 at the facility. POA #431 revealed this was the fourth fall that required an ER visit. The other three falls were on 04/10/25, Resident #125 had a fall and was found to have a lumbar fracture. In June 2026, Resident #125 got up from her wheelchair, fell and hit her head, was transported to the ER and had to have staples near the back of her head. On 07/07/25, Resident #125 was found by the nursing station on the floor and had fallen and had a hip fracture. During an interview on 04/16/25 at 8:45 A.M., the Administrator revealed she was unable to provide Resident #125's comprehensive fall investigations including witness statements because they were QAPI. The Administrator stated she was unable to read the investigations to the surveyor because the investigations were QAPI. During an interview on 04/16/26 at 9:20 A.M., the Administrator, the Director of Nursing (DON) and Director of Clinical Services (DCS) #429 reviewed the investigations and answered questions but did not let the surveyors review the fall investigations and did not read the investigations to the surveyors. Resident #125 had a fall on 04/10/25 and she was trying to ambulate on her own in the room without staff assistance. Resident #125 heard voices and was trying to see what was happening in the hall. The immediate intervention was to encourage Resident #125 to be in the common area when she was awake. DCS #429 indicated the root cause of the fall was due to orthostatic hypotension blood pressure but confirmed she did not see an orthostatic blood pressure recorded in Resident #125's progress notes when she had the fall. DCS #429 was unable to provide details of events leading up to the fall such as when Resident #125 was last seen etcetera (etc.). DCS #429 confirmed Resident #125 was wearing footwear when she fell. On 05/10/25, Resident #125 was found sitting on the floor in front of her wheelchair. DCS #429 indicated Resident #125 wanted to come out of her room, but she was in isolation and was restless. DCS #429 stated the intervention was the staff staying with Resident #125 until she was no longer restless. On 06/02/25, DCS #429 revealed Resident #125's daughter called to notify the nurse that Resident #125 sat on the arm of her recliner and fell to the floor. DCS #429 confirmed Resident #125 was not wearing proper footwear and had nothing on her feet. The immediate intervention was non-slip socks. DCS (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	#429 revealed the predisposing factors were impaired memory, confusion, weakness, gait imbalance, improper footwear and she had a C Diff infection. The DON indicated Resident #125 was antsy and restless because she could not come out of her room for C. diff. When asked what interventions were provided when Resident #125 had restlessness and was being antsy, the DON said she had a fidget blanket but confirmed the fidget blanket was not initiated until 02/17/26. No additional interventions were provided related to Resident #125's restlessness and being antsy. DCS #429 revealed Resident #125 was often antsy and restless even when she wasn't in isolation for C Diff. Resident #125 had an unwitnessed fall on 06/04/25 and she was moved to a room closer to the nursing station for more interaction and oversight. DCS #429 stated Resident #125 was self-ambulating, fell and was found next to her rollator. Resident #125 was last seen about 10 minutes prior to the fall. An intervention was to complete safety checks every 15 minutes while Resident #125 was in isolation and when asked for the evidence that the safety checks were completed the DON and DCS #429 indicated they would look for the safety checks. No evidence was provided that showed the safety checks were completed every 15 minutes while Resident #125 was in isolation for C Diff. DCS #429 indicated on 07/07/25, Resident #125 was taken off the secured unit because she was not ambulating, not exit seeking and the daughter agreed and assisted with the move. Resident #125 had a fall by the nursing station and was observed sitting in front of the scheduler's door and leaning on the door. Resident #125 was last seen about 20 minutes prior to the fall sitting in her padded wheelchair. Resident #125 said she was getting help with getting up. The new intervention was a dump wheelchair. Resident #125 had an intertrochanteric right femoral fracture and was not transported to the hospital because the family did not want her to be sent to the ER. The family wanted her to have an orthopedic appointment and to consult hospice services. On 07/14/25, the facility found out Resident #125 was transported from the orthopedic appointment to the hospital and was going to have emergency surgery for her hip fracture. DCS #429 revealed on 02/13/26, Resident #125 had a fall early in the morning in the dining area of the secured unit. The nurse was passing medications and when she walked back to the dining area, she found Resident #125 on the floor. Resident #125 stated her face and hip hurt and she was transported to the ER. Resident #125 returned to the facility on [DATE]. DCS #429 indicated she was not sure what caused the fall. A new intervention was a wedge cushion to the left side of the padded wheelchair to help with positioning. DCS #429 indicated Resident #125 passed away on 02/20/26. An email was sent on 04/16/26 at 4:20 P.M. to the DON and the Administrator and requested the fall investigation to determine if the facility completed comprehensive investigations and determined the root cause for the falls pertaining to the following dates: 04/10/25, 05/10/25, 06/02/25, 06/04/25, 07/01/25, 07/07/25 and 2/13/26. There was no response to the email, and investigations were not provided during the survey. During an interview on 04/20/26 at 3:19 P.M., Certified Nursing Assistant (CNA) #357 revealed she was working on 02/13/26 when Resident #125 experienced a fall. CNA #357 revealed LPN #364 was very busy administering medications and providing treatments and couldn't watch residents closely. CNA #357 indicated on 02/13/26 when Resident #125 fell, there was one other aide (CNA #314) and a nurse (LPN #364) working. CNA #357 revealed CNA #314 and herself were providing morning care to residents and assisting them out of bed. Resident #125 was assisted out of bed at around 5:30 A.M. and taken to the dining room and was put in a relaxed position in her padded wheelchair. Resident #125 was sitting in a semi reclined position but not tilted back. CNA #357 revealed LPN #364 was in the dining room and she was in Resident #55's room with CNA #314 when they heard LPN #364 yell. LPN #364 was yelling out that a resident was on the floor. LPN #364 told CNA #357 that she took medication to a (unidentified) resident and heard a thud and found Resident #125 on the floor. CNA #357 revealed when the day shift aides came in for work and found out Resident #125 had fallen and been taken to the ER; they told her Resident #125 had been restless in her chair during the day shift on 02/12/26. CNA #357 indicated the day shift aides did not tell her that in report when they were leaving for the day (02/12/26). CNA #357 stated she received report from the day shift CNA, but they did not tell her (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #125 was scooting forward and trying to get out of her chair. Resident #125 was trying to reach for something in the air that was not there. During an interview on 04/20/26 at 4:10 P.M., the DON confirmed Resident #125 was not wearing proper footwear when she fell on [DATE]. During a telephone interview on 04/22/26 at 9:09 A.M., CNA #347 revealed on 02/13/26, LPN #364 last saw Resident #125 about five to ten minutes before she fell and CNA #347 last saw Resident #125 about 10 to 15 minutes before she fell. CNA #347 indicated she assisted Resident #125 to the dining room and made sure the wheelchair was locked before she walked away. No activity was provided because Resident #125 appeared to go back to sleep and was not moving around in her chair. CNA #347 did not remember if Resident #125's wheelchair was dumped, but she was in a reclining, relaxed position, and not tilted back. CNA #347 indicated Resident #84 was in the dining room with Resident #125 when Resident #125 fell. Review of an email sent from the Administrator dated 04/22/26 revealed the Administrator stated Resident #125 was last seen within approximately ten minutes before she fell on [DATE], her chair was a dump chair and presented at baseline in the dining room prior to the fall. Attempts to interview LPN #364 and CNA #314 during the survey were unsuccessful. Review of the facility policy titled Fall Management and Incident Intervention Protocol revised 07/2022 revealed it was the policy of the facility to conduct an investigation into the potential causative factors for each resident incident, including those classified as a fall. In addition, residents would be assessed as to their risk of sustaining a fall. Interventions would be implemented and evaluated in order to decrease the incidence of residents, including falls, and to minimize the risk of injury. New interventions would be added to the resident plan of care and would be communicated to the relevant nursing staff. All falls would be reviewed by the Focus Group. Members would review events of the incident and discuss possible recommendations and alterations to the resident's plan of care. Review of the National Institute for Health's National Library of Medicine publication titled Can Agitated Behavior of Nursing Home Residents with Dementia be Prevented With the Use of Standardized Stimuli dated June 2023, included studies have shown that non-pharmacological interventions could be effective in decreasing agitation without the risk of the potential side-effects of medication, while simultaneously address the underlying unmet needs of the older person. As most nursing home residents spend much of their time unoccupied, a significant portion of their agitation is attributable to unmet needs related to boredom and confusion. Studies have found music, using simulated animal-assisted therapy such as a stuffed or robotic animal, social contact, structured activities, and self-identity interventions show effects in lowering agitation. This deficiency represents non-compliance investigated under Complaint Number 2572317.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, staff interview, and review of facility policy, the facility failed to ensure residents meals were palatable and at a appetizing temperature. This had the potential to affect all 113 residents receiving meals from the kitchen. The facility identified there were no residents who were nothing by mouth. The facility census was 113. Findings include: Observation on 04/14/26 at 11:48 A.M. with [NAME] #407 of steam table food temperatures revealed ground beef 150 degrees Fahrenheit (F), Spanish rice degrees 173 F, pureed ground beef degrees 145 F, pureed Spanish rice 166 degrees F, gravy 160 degrees F. Observation on 04/14/26 at 11:53 A.M. revealed tray line was initiated. First resident room tray cart for the 500-hall left the serving station at 12:05 P.M. Second resident room tray cart for the 200-hall left at 12:14 P.M. Third resident room tray cart for the 100-hall left at 12:20 P.M. The 200-hall dining room resident meals were finished at 12:52 P.M. A test tray was completed on 04/14/26 at 12:53 P.M. with [NAME] #407. Temperatures taken were as follows: ground beef was 118 degrees F, Spanish rice was 115 degrees F, pureed ground beef was 125 degrees F, and pureed Spanish rice was 117 degrees F. Following tasting the ground beef, Spanish rice, pureed ground beef, and puree Spanish rice, [NAME] #407 confirmed the Spanish rice was warm, but would have preferred it to be warmer. The pureed beef was well seasoned but was not warm enough and the pureed Spanish rice was also not warm enough for preference. Review of the facility policy titled Food Preparation and Service dated 10/2014 revealed food will be prepared by methods which ensure retention of flavor, appearance and nutrients. Food will be maintained at proper temperatures during service and transported in a sanitary manner. Food will be served at acceptable temperatures, each type of food having an appropriate temperature.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interview, and facility policy review, the facility failed to ensure refrigerated medications were kept in a safe and sanitary manner in accordance with accepted professional practices to maintain the efficacy of medication and ensure expired medications were not kept past the recommended expiration date. This affected Residents #5, #9, #12, #18, #19, #32, #38, #50, #51, and #96 and had the potential to affected residents who receive medications from the 200-hall storage area. The facility census was 113. Findings include: Observation on 04/15/26 at 11:46 A.M. with Registered Nurse (RN) #397 revealed the 200 Hallway medication storage area had one stock bottle of Nicotinamide Adenine Dinucleotide (NAD) (vitamin) 1,000 milligram (mg) tablets that expired on 03/2026. The 200 Hallway medication refrigerator in the medication storage area had a large frozen meal was in the freezer compartment and a large clear plastic bag which contained an unidentified sandwich and fruit that was placed in the medication refrigerator alongside the resident's refrigerated medications. The resident's refrigerated medications included: two Adalimumab injectors (treats autoimmune disorders for Residents #32 and #51), one Mounjaro auto injector (weight loss medication for Resident #19), four Pantoprazole suspension bottles (treats acid reflux for Resident #12), one Ozempic auto injector (weight loss medication for Resident #19), five Lantus Insulin auto injector pen (treats high blood sugars for Residents #5, #12, #18, #96, and facility stock), nine Humalog Insulin (treats high blood sugars for Residents #9, #12, #38, #40), one Lispro insulin auto injector pen (treats high blood sugars for Resident #9), facility stock supply of five boxes of Tylenol suppositories (rectal insert to treat fever and pain), facility stock of bisacodyl suppositories (aides in bowel movement), and one each of facility stock Novolog and Lantus Insulins. Interview with RN #397 on 04/15/26 at 11:50 A.M. confirmed all findings of expired stock bottle of NAD and presence of food in the refrigerator and freezer in the designated medication refrigerator. Review of the facility policy titled Medication Storage Policy revised 8/2021 revealed all medications are maintained behind a locked door that cannot be accessed by unlicensed personnel. The policy did not refer to medication refrigerator storage protocols. The facility policy titled Medication Administration Policy, revised 03/2022, revealed all medications are administered in a safe and sanitary manner.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on record review, staff interviews, observations, and review of the facility policy, the facility failed to ensure residents received the food according to the menu, recipe, and therapeutic spreadsheet. This affected Residents #9, #14, #19, #22, #47, #53, #63 and #115. The facility identified two residents were on a pureed diet. The facility census was 113. Findings include: Review of the facility menu for week four-day 24 lunch revealed the menu listed soft shell beef tacos, lettuce, tomatoes, shredded cheese, salsa, Spanish rice, and a cookie to be served. a. Review of the facility recipe called Beef Tacos Soft Shell revealed recipes ingredients listed were ground beef, taco seasoning mix, water, six-inch flour tortilla, finely shredded cheddar cheese, fresh diced tomato, shredded lettuce, sour cream and taco sauce. Assemble each taco with 1.5 ounces of meat, 0.25 ounces of shredded cheese, 0.5 ounces of diced tomatoes, one-fourth cup of shredded lettuce and one tablespoon of sour cream. Place the sour cream on the edge of the tortilla and then roll it up. Observation and interview on 04/14/26 at 11:44 A.M. with [NAME] #334 confirmed salsa and sour cream were on the menu for lunch but the facility was out the sour cream and salsa and were not sending it with the trays. Observation on 04/14/26 at 12:23 PM revealed an unidentified aide came to the door and asked for salsa for Resident #19 and was told they did not have any salsa in the serving station to give the resident. Observation on 04/14/26 at 12:35 P.M. revealed the dietary staff ran out of diced tomatoes for the eight remaining resident trays. The following residents meals were not provided the option to have tomatoes on their tacos: Residents #9, #22, #47, #53, #63, and #115. Two additional residents did not have the option to receive tomatoes and were unable to be identified. [NAME] #334 confirmed they ran out of tomatoes for tray service at the time of the observation. Interview on 04/14/26 at 1:06 P.M. with Dietary Manager #384 confirmed salsa and sour cream were listed on the menu and stated she was unsure why staff had not gone to the main kitchen to get it for meal service. Dietary Manager #384 also stated maybe the cook had put the salsa into the meat when cooking the beef and confirmed it was not listed as an ingredient on the cooking portion of the recipe. b. Review of the facility production sheet for Week four, day 24 lunch revealed the pureed diets were supposed to receive a #40 scoop (1.6 tablespoon) of pureed peanut butter cookie. Observation and interview on 04/14/26 at 12:45 P.M. revealed Resident #14, who had a pureed diet order, was not provided with the pureed cookie listed on the menu. [NAME] #334 confirmed they did not make the pureed cookies and usually give the residents on a pureed diet a magic ice cream cup instead. Interview on 04/14/26 at 1:06 P.M. with Dietary Manager #384 confirmed physician ordered diets were to be followed and dietary staff were to provide the items listed on the dietitian approved menus. Review of the facility policy titled 'Food Preparation and Service dated 10/2014 revealed portion control will be achieved through: portions are indicated on a regular and therapeutic diet menus. Review of the facility policy titled Mechanically Altered Diets Policy dated 04/2022 revealed pureed diet will receive all food pureed until smooth according to the standardized recipe. The mechanical soft and pureed diets are specified on the spreadsheet with the items and portions to be served for each diet.		

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews and review of facility policy, the facility failed to ensure staff followed proper hand hygiene and personal hygiene in the kitchen when serving food. This had the potential to affect 57 residents who resided on the 100, 200 and 500 halls and were receiving meals from the 200 hall serving station. The facility indicated no residents received nothing by mouth. The facility census was 113. Findings include: Observation and interview on 04/14/26 at 11:38 A.M. in the 200-hall dietary serving station which serviced 100, 200 and 500 hall residents revealed [NAME] #407, who had a beard, was not wearing a beard net. [NAME] #407 confirmed he was not wearing a beard net and stated he had to go to the main kitchen to get one since there were none in the 200 serving station. Observations and interview on 04/14/26 at 12:29 P.M. revealed Cooks #401 and #407 leaving the kitchen carrying three resident plates each with their gloved hands to deliver to the dining room. At 12:32 P.M., Cooks #401 and #407 opened the kitchen door with their gloved hand and returned to the serving line. They did not perform hand hygiene and change gloves. [NAME] #401 and #407 confirmed they had not washed their hands or changed gloves after leaving the kitchen prior to going back to their serving stations in the kitchen. Observation and interview on 04/14/26 at 12:49 P.M. revealed Dietary Aide #333 entered the serving area of the kitchen and walked back to the back of the room where the dish machine was and did not put on a hair net. [NAME] #407 confirmed Dietary Aide #333 was supposed to have a hair net on in the kitchen. Review of the undated facility policy titled Plastic Gloves revealed hands are to be washed when entering the Dietary Department and before putting on the plastic gloves. Review of the undated facility policy titled Sanitation and Food Handling revealed personnel will observe personal cleanliness and exercise satisfactory food handling techniques. Employees must wash their hands and this included when returning to the dietary department for any reason and before serving food. Review of the undated facility policy titled Personnel Management/Dress Code revealed hair restraints must be used when in the kitchen. Men with beards must use a covering over the facility hair when serving food or preparing food. Hands must be washed when entering the kitchen.		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, resident and staff interviews, and interview with optometry staff, the facility failed to ensure a resident received eye glasses in a timely manner. This affected one (Resident #81) of two residents reviewed for ancillary services. The facility census was 113. Findings include: Review of the medical record for Resident #81 revealed an admission date of 01/03/25. Diagnoses included chronic obstructive pulmonary disease and diabetes mellitus. Review of Resident #81's care plan dated 01/06/25 and last revised on 06/02/25 revealed under the area of resident care, there was an intervention to encourage Resident #81 to wear glasses when out of bed and to assist with care of glasses as needed. Review of the optometry note dated 10/06/25 revealed Resident #81's chief complaint was blurry vision. New glasses prescription was updated and new frames were selected for bifocals, distance and near vision. Glasses were to be ordered and shipped to the home once insurance once verified. If glasses were not covered by insurance, a self pay option would be offered to Resident #81 to have an option for the glasses order to be fulfilled. Review of the Social Service Designee (SSD) #314's optometry list revealed Resident #81 was last seen on 10/06/25. Review of the annual Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #81 was cognitively intact. Resident #81 could see adequately with appliance. From 10/06/25 to 04/13/26, there were no additional notes with a follow up to Resident #81's new eye glasses that optometrist said would be ordered. Interview and observation of Resident #81 on 04/13/26 at 10:30 A.M. revealed she was waiting for new glasses and had been on the list for months. She held up a pair of glasses missing a stem. She stated she was seen by the eye doctor but never received a new pair of glasses. Interview with SSD #314 on 04/16/26 at 3:02 P.M. revealed she was not aware Resident #81 was waiting on a pair of glasses. Telephone interview on 04/20/26 at 12:50 P.M. with third party Eyewear Coordinator (EC) #428 verified Resident #81 was seen on 10/06/25 and was to get new glasses after insurance verification. She stated the facility emailed her on 04/16/26 asking her to look into this during annual survey. EC #428 verified she did not have any evidence Resident #81 received a private pay notification after insurance denial in October. She stated private pays take a few days longer but it was hard to keep up with private pay letters due to the volume of patients they had. She stated she was communicating with SSD #414 on the cost of the glasses to expedite delivery. She verified it should not take six months to get eye glasses. Subsequent interview on 04/20/26 at 2:34 P.M. with SSD #414 revealed she did not receive progress notes from the 10/06/26 optometry visit nor did she follow-up with EC #428 regarding visit outcome in a timely manner. Review of the facility policy titled Vision and Hearing Policy, dated 08/2019, revealed the facility would ensure residents received proper treatment and assistive devices to maintain vision and hearing abilities.		

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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, hospice staff interview, review of the facility hospice agreement, and review of facility policy, the facility failed to ensure hospice was part of the care conference and a hospice provided care plan was part of the medical record for Resident #28. This affected one (Resident #28) of one reviewed for hospice. The facility identified 17 residents who were on hospice. The facility census was 113. Findings include: Review of the medical record for Resident #28 revealed an admission date of 03/27/26. Diagnoses included malignant neoplasm of unspecified bronchus or lung, palliative care. The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #28 had moderate cognitive impairment and was receiving hospice services. The resident's care plan did not have evidence of a hospice provided care plan with specified care needs, and who would provide the needed care for Resident #28. Review of the physician order dated 03/27/26 for Resident #28 revealed an order to admit to hospice services with a diagnosis of lung cancer with metastasis with six months or less to live. Review of the social services progress note dated 04/01/26 for Resident #28 revealed a care conference with facility department managers and Resident #28. Hospice was not noted to be a part of the care conference. Review of the facility's hospice binder revealed a signed hospice agreement for Resident #28 dated 03/27/26. No hospice provided care plan was found in the binder. Interview on 04/16/26 at 2:56 P.M. with Registered Nurse (RN) #356 revealed the hospice nurse or aide makes their visit notes in their own electronic medical record but staff do not have access to it. If hospice writes order, they write them in the hard chart. RN #356 confirmed the hospice binder and medical record for Resident #356 did not have a hospice care plan. Interview on 04/20/26 at 11:29 A.M. with the Director of Nursing (DON) revealed the hospice nurse will communicate with the nurse and verbally give updates or write orders if there were changes for the resident. The DON stated hospice does not print hospice visit summaries unless the facility requests them and also confirmed no visit summaries were found in the electronic or paper medical record for Resident #28. Interview on 04/20/26 at 12:22 P.M. with Hospice Nurse #427 confirmed the hospice care plan was not in the hospice binder or in the medical record as required. Interview on 04/20/26 at 2:16 P.M. with Social Services Designee (SSD) #414 confirmed a resident receiving hospice will have a care conference upon admission, quarterly and as needed for significant changes. SSD #414 confirmed she does not usually communicate with hospice and also confirmed hospice was not a part of the care conference for Resident #28 on 04/01/26. Review of the facility hospice agreement revealed an agreement dated 04/01/22 by the facility with the hospice company. Under letter A titled Services revealed the facility will provide facility basic services, inpatient acute care, and/or respite care to hospice patients 24 hours a day, seven days a week in accordance with the hospice plan of care. Under section B2 Hospice Responsibilities revealed hospice shall furnish facility a copy of the hospice patient's Hospice Plan of Care. Hospice will specify to the facility the care to be provided to the hospice patient by the facility. The designated coordinator of the interdisciplinary group (IDG) will assess conformance with the Hospice Plan of Care. Review of the facility policy titled Hospice dated August 2014 revealed meeting will be held between Hospice staff, staff and family/resident/representative for care plan generation and continuity of care.		