

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365904	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Saint Joseph Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2308 Reno Drive NE Louisville, OH 44641	
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 observation, medical record review, staff and representative interview, and facility policy review, the facility failed to develop and implement a comprehensive and individualized pressure ulcer prevention program to ensure monitoring and assessments were completed timely and appropriately for pressure ulcers and wound care was completed as ordered. This affected two residents (#5 and #61) of three reviewed for pressure wounds. The facility census was 57. Actual Harm occurred beginning on 11/04/25 to Resident #5, who was cognitively impaired, at risk for pressure ulcer development and required staff assistance for activities of daily living care, when the resident was identified to have moisture associated skin damage (MASD) to the coccyx that went unassessed and unmonitored resulting in a decline of the wound. On 12/29/25 the skin impairment was assessed by Wound Nurse Practitioner (NP) #201 to be a Stage III (a wound characterized by full-thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling) pressure ulcer/wound measuring 1.5 centimeters (cm) length by 0.6 cm width by 0.3 cm depth. The facility failed to ensure individualized and comprehensive interventions were in place to prevent the decline in the resident's skin and identification of a Stage III pressure ulcer. Findings include:1. Review of the medical record for Resident #5 revealed an admission date of 11/06/15 with diagnoses that included Alzheimer's disease, diabetes mellitus, idiopathic progressive neuropathy, venous insufficiency, obesity due to excess calories, generalized muscle weakness, oropharyngeal phase dysphagia, and anxiety disorder. Resident #5 received hospice services effective 06/12/25 for end stage Alzheimer's disease. Review of the physician's orders dated 05/10/18 revealed orders for pressure reducing cushion to wheelchair, encourage frequent positioning, and float heels while in bed as tolerated. Review of the plan of care revised 06/29/18 revealed Resident #5 was at risk for pressure wounds. Interventions included apply house barrier cream as directed, offer to lay down after meals, use bariatric mattress, change position at least every two hours, check body with daily care, notify physician of any changes in skin integrity, encourage good oral intake, float heels while in bed, do not use briefs while resident in bed, and provide hygiene care every shift and as needed. Review of the physician's order dated 02/11/20 revealed an order to lay Resident #5 down in bed after meals for skin integrity. Review of the physician's order dated 03/11/22 revealed an order to complete a body assessment once weekly to observe for skin integrity and notify physician of any changes. Review of the care plan revised on 03/30/22 revealed Resident #5 had activities of daily living (ADL) self-care performance deficit. Interventions included utilizing Hoyer lift for transfers with two staff assist, lay resident down after meals, offering nail care on shower days, do not use briefs while (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 0686 Level of Harm - Actual harm Residents Affected - Few	resident in bed, and use custom tilt wheelchair. Review of the care plan revised on 02/05/25 revealed Resident #5 was at risk for impaired skin integrity. Interventions included educate on importance of keeping skin clean and moisturized, evaluating skin for areas of blanching or redness, keep skin clean and well lubricated, and provide skin care per facility guidelines. Review of the physician's order dated 03/21/25 revealed order for Chamosyn ointment (multi-purpose skin protectant ointment) with routine care to sacrum for moisture-associated skin damage (MASD). Review of the Braden Scale assessment dated [DATE] revealed Resident #5 was at high risk for developing pressure ulcers. Review of the Braden Scale assessment dated [DATE] revealed Resident #5 was at moderate risk for developing pressure ulcers. Review of the Braden Scale assessment dated [DATE] revealed Resident #5 was at moderate risk for developing pressure ulcers. Review of the Medicare Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #5 had Brief Interview for Mental Status (BIMS) score of 01 indicating severe cognitive impairment. Resident #5 was dependent on staff for all ADLs including bathing, bed mobility, transfers, and ambulation. Resident #5 was always incontinent of bowel and bladder. Resident #5 was at risk for developing pressure ulcers. Review of the physician's order dated 11/04/25 revealed order to cleanse open area to coccyx with normal saline (NS), pat dry, apply triad paste and cover with foam dressing daily and as needed (PRN). This order was discontinued on 12/23/25. (Please note, the facility Wound Registered Nurse (RN) #193 described the area as MASD on 11/04/25 when it was initially found however the order entered was described as an open area. There was no initial assessment to verify if the area was open or MASD.) Further review of the medical record revealed no evidence of an initial assessment to address the open area to coccyx and treatment order dated 11/04/25. There was no evidence of wound measurements being identified. Review of physician's progress note dated 11/05/25 revealed a follow up appointment for chronic medical conditions. It was noted Resident #5 had a treatment for an open area on coccyx. There was no evidence of any evaluation of the wound. Review of the nursing progress note dated 11/07/25 authored by Wound Registered Nurse (RN) #193 revealed Resident #5's coccyx wound was again moist and pink. The note included there was scant drainage from wound. Noted previous good results with triad paste and foam dressing. Plan to continue with Triad paste and foam dressing. Review of hospice interdisciplinary group (IDG) meeting notes dated 11/19/25 revealed the facility wound nurse reported a Stage II pressure wound (defined as partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer) to the coccyx. The facility wound nurse reported (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	should have a system to assure assessments were completed timely and appropriately, changes in condition were recognized, evaluated and reported to the practitioner/physician/family, and wounds were addressed. It was noted if pressure ulcers were not treated when discovered, they quickly get larger, become very painful and often times can become infected. Review of the facility policy Pressure Ulcers/Skin Breakdown & Clinical Protocol dated March 2014 revealed nursing staff would describe, document, and report the following a full assessment (described as the location, stage, size, and presence of exudate or necrotic tissue) of the pressure wound, pain, mobility status, current treatments, and active diagnoses. During physician visits the resident would be evaluated and the progress of wound healing would be documented. Review of facility policy Pressure Ulcer Treatment dated September 2013 revealed wound information including appearance, size, drainage, and any evidence of pain or discomfort should be documented in the resident's medical record. 2. Review of Resident #61's medical record revealed the resident was admitted on [DATE] with diagnoses including nondisplaced bimalleolar fracture of the left lower leg, fibromyalgia and depression. Review of Resident #61's admission MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #61's pressure wound care plans revealed to apply skin prep daily and leave open to air every day-shift. Review of Resident #61's Wound Care progress note dated 12/22/25 at 10:15 A.M. revealed the resident had an unstageable pressure ulcer (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) related to the cast/orthopedic brace to the left heel. The pressure ulcer measured 1.8 cm length by 1.5 cm width by undetermined depth with 100% eschar. The treatment orders included cleanse with normal saline, apply skin prep and leave open to air. Observation on 12/30/25 at 8:48 A.M. with Registered Nurse (RN) Wound Nurse #193 revealed she washed her hands, applied gloves and applied skin prep to the left heel. RN Wound Nurse #193 did not cleanse the left heel first with normal saline and was not wearing protective isolation gown while completing the resident's wound care. Interview on 12/30/25 at 8:54 A.M. with RN Wound Nurse #193 confirmed she did not wear a protective isolation gown while completing the wound care to the resident's left heel and she confirmed the resident was not placed in enhanced barrier precautions as required. RN Wound Nurse #193 also confirmed she did not cleanse the resident's left heel prior to applying the skin prep because she stated the skin prep would not stick. Review of the Pressure Ulcers/Skin Breakdown policy revised 03/2014 revealed the physician would authorize pertinent orders related to wound treatments, including wound cleansing and debridement approaches, dressing and application of topical agents if indicated for the type of skin alteration.		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the CASPER Report 1705D (Staffing Report) for quarter three of fiscal year 2025 ([DATE]-[DATE]), review of facility nursing schedules, facility daily staffing report postings, and interview with staff, the facility failed to ensure eight consecutive hours of registered nursing coverage per day. This had the potential to affect all residents residing in the facility. The facility census was 57. Findings include: Review on [DATE] of the Centers for Medicare and Medicaid (CMS) CASPER Report 1705D for quarter three of fiscal year 2025 ([DATE]-[DATE]) revealed no Registered Nurse (RN) coverage for more than eight consecutive hours on [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Review on [DATE] of the facility daily nursing schedules revealed no RN assigned/scheduled or present working on [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Further review revealed all the infraction dates were on a Saturday or Sunday. Review on [DATE] of the facility's required daily staffing report postings revealed no RN coverage on [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Interview on [DATE] at 10:56 A.M. with the Facility Scheduler (FS) #131 verified no RNs were scheduled or could show evidence of RNs working in facility for 8 or more consecutive hours on [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Interview on [DATE] at 11:04 A.M. with the facility's Human Resource Manager (HR) #197, who oversees scheduling, revealed the facility had an RN on a leave of absence in May and June of 2025. HR #197 further reported she was unaware at the time of the RN coverage requirement for eight consecutive hours per day and that when the facility became aware of this in July of 2025, they immediately remedied the situation. HR #197 further identified that the facility has hired some new RN's as well as scheduling RNs in management on a weekend rotation until staffing levels meet the 8-hour daily RN coverage. Interview on [DATE] at 11:30 A.M. with the facility Administrator revealed she was aware of the RN requirement for 8 consecutive hours per day not being followed in May and June of 2025 and once the facility became aware of the concern, they immediately began scheduling RN management on a weekend rotation until new RN's could be hired to meet this requirement.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, staff interview, and policy review, the facility failed to maintain a clean and sanitary dumpster area. This had the potential to affect all residents residing in the facility. The facility census was 57. Findings include: Observation on 12/29/25 at 8:26 A.M. with Dietary Manager (DM) #74 revealed significant unbagged debris mostly consisting of used gloves surrounding the dumpster. There were also various furniture items and housewares piled up along the fence surrounding the dumpster. Interview on 12/29/25 at 8:28 A.M. with Dietary Manager #74 confirmed the area was not kept clean and free of debris. Review of the facility policy Waste Disposal (undated) revealed trash bags would be sealed prior to removing them from the facility. Trash would be deposited into a sealed container outside the premises.		

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation, staff interview, and facility policy review, the facility failed to ensure residents receiving puree diet were served the appropriate portion size and complete menu items. This affected five residents (#5, #6, #8, #9, and #11) of five identified as receiving a puree diets. The facility census was 57. Findings include: Observation on 12/30/25 at 11:00 A.M. with [NAME] #70 revealed the puree ham, green beans, and potato casserole (main menu) were served with a number 10 scoop with an ivory handle (approximately three to four ounces) and the puree Sheppard's pie (alternate menu) was served with a number 10 scoop with an ivory handle. [NAME] #70 confirmed her scoop sizes for the lunch service. Observation on 12/30/25 from 11:13 A.M. to 12:05 P.M. revealed there was no puree bread served to Residents #5, #6, #8, #9, and #11. Interview on 12/30/25 at 12:06 P.M. with [NAME] #70 confirmed she had not served puree bread and there was not puree bread available on the steamtable to serve. Review of the facility menu revealed lunch on 12/30/25 was ham, green beans, and potato casserole with choice of roll, and frosted chocolate cake. A puree diet would consist of the pureed casserole, pureed bread, and pureed cake. The alternate was beef Sheppard's pie and mashed potatoes. Review of the diet spreadsheet for lunch on 12/30/25 revealed the puree ham, green beans, and potato casserole serving size was an eight-ounce ladle and the puree beef Sheppard's pie serving size was a number six scoop (approximately five to six ounces). Interview on 12/30/25 at 12:20 P.M. with Dietary Manager #74 confirmed the portion sizes for puree main menu and alternative menu served at the lunch meal were inadequate and puree bread was not served. Review of the facility policy Portion Control undated revealed portions that were too small result in the individual not receiving the nutrients needed. Menus should be posted on tray line so dietary staff could refer to the proper portion sizes for each diet type. Dietary staff would receive training and oversight to assure appropriate portion sizes were followed.		

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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. Based on review of medical records, review of facility policies, self-reported incident review, and resident and staff interviews, the facility failed to investigate and self-report an alleged incident of verbal abuse. This affected one (#3) of one residents reviewed for abuse. The facility census was 57. Findings include: Review of the medical record of Resident #3 revealed admission to facility on 09/18/20 with diagnoses of Parkinson's disease (progressive disease affecting balance and fine motor skills), depression, atrial fibrillation (irregular heart rate), anxiety, post-traumatic stress disorder, high blood pressure, and chronic constipation. Review of Resident #3's most recent quarterly minimum data set (MDS) assessment completed on 09/25/25 revealed a brief interview for mental status score of 7 out of 15 indicating moderate cognitive impairment and a depression score of 12 indicating moderate depression. No hallucinations or delusional behaviors noted. Resident #3 required substantial assistance with bathing, transferring, and mobility. Further review revealed Resident #3 required a maximum of two persons to assist with toileting and transfer from bed to wheelchair. Review of Resident #3's treatment administration record (TAR) for October 2025 revealed on 10/26/25 a new treatment was added for the 7:00 P.M. to 7:00 A.M. shift that Resident #3 was not to have male staff providing personal care assistance. Review of the State of Ohio self reported incident (SRI) tracking software on 12/30/25 revealed no evidence of a facility SRI of verbal abuse associated with Resident #3. Interview on 12/30/25 at 3:25 P.M. with Resident #3 revealed she did not feel safe around a particular staff member who was a black male who had worked at the facility for a few months, identified as certified nurse aide (CNA) #118. Resident #3 revealed that CNA #118 had verbally insulted her and called her a liar. Resident #3 further reported that she did not trust CNA #118 nor feel safe with him providing care and she was concerned CNA #118 would take her belongings or harm her. Resident #3 reported that this incident had happened a couple months back and the facility was made aware, but they think he is great and did not fire him. Resident #3 confirmed that CNA #118 has not been providing her care recently but that CNA #118 still worked at the facility. Interview on 12/31/25 at 10:08 A.M. with CNA #118 revealed he had not provided care to Resident #3 for a couple of months since she had made some allegations of verbal abuse against him. CNA #118 reported that he self-reported to the nurse on duty a couple of months ago that he heard from other staff that Resident #3 was reporting he was calling her a liar and accusing him of taking belongs. CNA #118 reported he was told by the nurse on duty that he (CNA #118) does not provide care to Resident #3 anymore. CNA #118 reported that if he was assigned the 600 hallway in which Resident #3 resided, he would switch off with a female team member for that room. CNA #118 assists in two person transfers with the presence of another female aide. Interview on 12/31/25 at 11:50 A.M. with the facility Administrator revealed she had not ever completed an SRI related to verbal abuse for Resident #3. The Administrator further reported that she was aware that Resident #3 did not like male caregivers and they had stopped allowing male caregivers to provide care to Resident #3 for a couple of months. Further interview revealed the Administrator was aware Resident #3 did not like CNA #118 and she attributed this to Resident #3 never being married, a retired teacher, and possibly having bias about male caregivers. Review of facility policy on Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property (revised 10/22) revealed the Administrator is responsible for reporting any alleged violations of abuse to the Ohio Department of Health within 24 hours of knowledge of the incident and complete a full investigation no later than five days from the report with documented details and conclusion related to the allegations.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on review of medical records, facility policy review, self-reported incident review, and resident and staff interviews, the facility failed to investigate an alleged incident of staff to resident verbal abuse. This affected one (#3) of one resident reviewed for abuse. The facility census was 57. Findings Include: Review of the medical record of Resident #3 revealed admission to facility on 09/18/20 with diagnoses of Parkinson's disease (progressive disease affecting balance and fine motor skills), depression, atrial fibrillation (irregular heart rate), anxiety, post-traumatic stress disorder, high blood pressure, and chronic constipation. Review of Resident #3's most recent quarterly minimum data set (MDS) assessment completed on 09/25/25 revealed a brief interview for mental status score of 7 out of 15 indicating moderate cognitive impairment and a depression score of 12 indicating moderate depression. No hallucinations or delusional behaviors noted. Resident #3 required substantial assistance with bathing, transferring, and mobility. Further review revealed Resident #3 required a maximum of two persons to assist with toileting and transfer from bed to wheelchair. Review of Resident #3's treatment administration record (TAR) for October 2025 revealed on 10/26/25 a new treatment was added for the 7:00 P.M. shift that Resident #3 was not to have male staff providing personal care assistance. Review of Resident #3's current care plan and Kardex revealed no care plans or task reflecting resident preference for no male care givers. Review of the State of Ohio self-reported incident (SRI) tracking software on 12/30/25 revealed no evidence of a facility self-reported incident (SRI) of verbal abuse associated with Resident #03. Interview on 12/30/25 at 3:25 P.M. with Resident #3 revealed she did not feel safe around a particular staff member who was a black male who had worked at the facility for a few months (identified as certified nurse aide (CAN) #118). Resident #3 revealed that CNA #118 had verbally insulted her and called her a liar. Resident #3 further reported that she did not trust CNA #118 nor feel safe with him providing care and she was concerned CNA #118 would take her belongings or harm her. Resident #3 reported that this incident had happened a couple months back and the facility was made aware, but they think he is a great and did not fire him. Resident #3 confirmed that CNA #118 has not been providing her care recently, but that CNA #118 still worked at the facility. Interview on 12/31/25 at 10:08 A.M. with CNA #118 revealed he had not provided care to Resident #3 for a couple of months since she had made some allegations of verbal abuse against him. CNA #118 reported that he self-reported to the nurse on duty a couple of months ago that he heard from other staff that Resident #3 was reporting he was calling her a liar and accusing him of taking belongs. CNA #118 reported he was told by the nurse on duty that he should not provide care to Resident #3 anymore. CNA #118 reported that if he was assigned the 600 hallway, in which Resident #3 resided, he would switch off with a female team member for that room. CNA #118 identified that he assists in two person transfers with the presence of another female aide. Interview on 12/31/25 at 11:50 A.M. with the facility Administrator revealed she had not ever completed an SRI or investigation related to allegation of verbal abuse for Resident #3. The Administrator further reported that she was aware that Resident #3 did not like male caregivers and they had stopped allowing male caregivers to provide care to Resident #3 for a couple of months. Further interview revealed the Administrator was aware Resident #3 did not like CNA #118 and she attributed this to Resident #3 never being married, a retired teacher, and possibly having bias about male caregivers. Review of facility policy on Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property (revised on 10/22) revealed the Administrator is responsible for reporting any alleged violations of abuse to the Ohio Department of Health within 24 hours of knowledge of the incident and complete a full investigation no later than five days from the report with documented details and conclusion related to the allegations.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure comprehensive assessments were complete and accurate. This affected four (#4, #5, #22, and #43) of 22 residents reviewed for accurate comprehensive assessments. Findings include:1. Review of Resident #43's medical record revealed the resident was admitted on [DATE] and readmitted on [DATE] with diagnoses including depression, Alzheimer's disease and repeated falls. Review of Resident #43's physician orders revealed an order dated 11/26/25 for cefdinir oral capsule 300 milligrams (mg) give one capsule by mouth two times a day for an urinary tract infection (UTI). Review of Resident #43's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] (with a seven-day look back from 11/27/25 to 12/03/25) revealed the resident exhibited moderate cognitive impairment, was on an hypnotic and not on an antibiotic. Review of Resident #43's medication administration records (MARs) and treatment administration records (TARs) revealed the last dose administered was on 11/27/25 upon rising. The MARs did not reflect the resident received a hypnotic during the seven-day look back period. Interview on 12/20/25 at 10:30 A.M. with the Director of Nursing (DON) confirmed the above findings. 2. Review of Resident #4's medical record revealed the resident was admitted on [DATE] and readmitted on [DATE] with diagnoses including mild cognitive impairment, unspecified dementia and difficulty in walking. Review of Resident #4's Quarterly MDS 3.0 assessment dated [DATE] (with a look back period period between 11/28/25 to 12/05/25) revealed the resident exhibited severe cognitive impairment, the resident received a hypnotic and an antianxiety. Review of Resident #4's physician orders and MARs did not reveal evidence the resident was ordered and/or received a hypnotic medication or an anxiety medication. Email interview on 12/30/25 at 2:45 P.M. with the Administrator confirmed the above findings. 3. Record review revealed Resident #22 was admitted to the facility on [DATE] and her diagnoses included dementia, dysphagia, abnormalities of gait/mobility, acute kidney failure, hypertension, diabetes, major depressive disorder, spinal stenosis, chronic kidney disease (CKD)-stage2, anemia, and anxiety disorder. She was alert and oriented to person, place, and time (A&Ox3). She was given hearing aides on 04/04/25. Record review of Resident #22's Minimum Data Set 3.0 (MDS) from 06/04/25, 09/04/25, and 12/05/25 revealed the use of hearing aides was not noted. Interview on 12/30/25 at 2:00 P.M. with the Director Of Nursing (DON) confirmed the MDS's from 06/04/25, 09/04/25, and 12/05/25 did not contain evidence of Resident #22 using hearing aides. 4. Review of the medical record for Resident #5 revealed an admission date of 11/06/15 and diagnoses included Alzheimer's disease, diabetes mellitus, idiopathic progressive neuropathy, venous (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	insufficiency, obesity due to excess calories, generalized muscle weakness, oropharyngeal phase dysphagia, and anxiety disorder. Review of the Medicare Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #5 was at risk for developing pressure ulcers/injuries. Resident #5 had one or more unhealed pressure ulcers/injuries. There was no stage selected for unhealed pressure ulcer/injuries. Further review of the medical record revealed no evidence of any pressure wounds at the time of the assessment or seven-day lookback period. Interview on 12/31/25 at 10:43 A.M. with the Director of Nursing (DON) confirmed Resident #5 did not have any pressure wounds at the time of the lookback period and the MDS section was marked in error.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews the facility failed to ensure residents had accurate care plans. This affected two residents (#10 and #45) of 22 residents reviewed for accurate care planning. Findings include: 1. Review of Resident #45's medical record revealed the resident was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including muscle weakness, history of falling, and acquired absence of the right leg below the knee. Review of Resident #45's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #45's fall care plans revealed an intervention dated 11/10/25 for dycem to the recliner for safety. The care plans did not reflect the dycem to the wheelchair. Review of Resident #45's physician orders revealed an order dated 11/10/25 for dycem to the wheelchair; and an order dated 12/24/25 for dycem to the recliner. No directions were specified for the order. Interview on 12/29/25 at 4:15 P.M. with Resident #45 confirmed he did not like the dycem non-slip mat to the wheelchair or recliner and had staff remove it. Interview on 12/30/25 at 9:19 A.M. with the Director of Nursing (DON) revealed Resident #45 should have dycem in his recliner as that was a fall intervention. She stated she was unaware it was removed and she would address the intervention. Interview on 12/31/25 at 10:43 A.M. with the DON revealed Resident #45 was talked to and he did not want the dycem in place and it should have been removed from the physician orders and care plan. Review of fall policy, dated March 2018, revealed the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. 2. Review of Resident #10's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses of unspecified displaced fracture of left humerus, need for assistance with personal care, muscle weakness, and polyarthritis. Review of Resident #10's admission MDS 3.0 assessment dated [DATE] revealed Resident #10 had no pressure areas but currently at risk for skin impairments. Resident #10 needed partial/moderate assistance with rolling left to right, sit to lying, and lying to sitting on the side of bed. Review of Resident #10's wound note, dated 12/08/25, revealed she had a Stage 2 pressure area to her left and right buttock. Review of Resident #10's physician order, dated 12/22/25, revealed to cleanse the wound with normal saline, apply collagen to open areas, and cover with a foam dressing daily and as needed. Review of Resident #10's skin care plan revealed she was at risk for skin impairment, but no actual skin impairment care plan was in place. Interview on 12/29/25 at 10:20 A.M. with Resident #10 revealed she's had wounds to her buttock for a long time and concerned they haven't healed. She stated the staff changed the dressings daily and assisted her as needed due to her left shoulder fracture. Interview on 12/30/25 at 3:19 P.M. with Registered Nurse (RN) #193 revealed Resident #10 had a remaining wound to her left buttock but her right buttock was healed. RN #193 revealed a Certified Nursing Assistant (CNA) found the open areas to Resident #10's buttock on 12/08/25 possibly during a shower. That same day the wound nurse practitioner assessed the wounds and ordered Triad cream and a foam dressing to be applied daily. The current treatment was to apply collagen and a foam dressing daily. RN #193 confirmed Resident #10 did not have an actual skin impairment care plan, she only had an at risk for skin impairment care plan. Review of the Care Plan Policy, dated 2011, revealed the plan of care included instructions needed to provide effective, person-center care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the residents. The care plan was updated as needed.		

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F 0684 Level of Harm - Minimal harm or potential for 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, record review, and interviews the facility failed to ensure a resident had interventions in place for monitoring of congestive heart failure. This affected one resident (#17) of one resident reviewed for congestive heart failure (CHF). Findings include: Review of Resident #17's medical record revealed the resident was admitted on [DATE] with diagnoses including chronic pulmonary edema and chronic CHF. Review of Resident #17's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had debility and cardiorespiratory conditions that included chronic pulmonary edema and heart failure. Review of Resident #17's care plan for nutrition/hydration related to CHF and pulmonary edema revealed an intervention dated 12/15/25 for daily weights as ordered for CHF monitoring. Review of Resident #17's physician orders revealed an order dated 12/13/25 for daily weights due to CHF. Review of Resident #17's weights from 12/13/25 to 12/30/25 revealed Resident #17 was missing daily weights on 12/16/25, 12/22/25, and 12/26/25. Review of Resident #17's progress note dated 12/28/25 revealed Resident #17 complained of shortness of breath. Resident's oxygen level was 87% on room air. The left upper lung was noted to have audible crackles and wheezing noted in the right upper lung. Resident #17 was placed on two liters of oxygen and breathing treatment administered. Review of Resident #17's progress note dated 12/28/25 revealed the resident was ordered a one-time dose of potassium, a one-time dose of Lasix, labs, and a chest x-ray. Interview on 12/30/25 at 1:38 P.M. with the Director of Nursing (DON) confirmed Resident #17 had daily weights missing and she would discuss the need for weights to be completed with the staff. Review of the policy weighing and measuring the resident, dated March 2011, revealed the purposes of this procedure are to determine the resident's weight and height, to provide a baseline and an ongoing record of the resident's body weight as an indicator of the nutritional status and medical condition of the resident, and to provide a baseline height in order to determine the ideal weight of the resident. Report information in accordance with facility policy and professional standards of practice.		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to honor resident food preferences. This affected two residents (#17 and #43) of three residents reviewed for nutrition. Findings include:1. Review of Resident #17's medical record revealed the resident was initially admitted on [DATE] with diagnoses including chronic pulmonary edema, congestive heart failure, and muscle weakness. Review of Resident #17's admission MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #17's nutrition care plan revealed an intervention dated 12/11/25 to provide substitutions for any food/fluid dislikes. Review of Resident #17's physician orders revealed an order dated 12/15/25 for four ounces of a nutritional supplement twice a day for decreased meal intake. Observation on 12/30/25 at 7:52 A.M. of Resident #17 revealed she received breakfast. She received milk, juice, orange juice, and water on tray with eggs and toast. A Certified Nursing Assistant (CNA) brought the resident ginger ale. Review of the current day's menu on 12/30/25 at 7:54 A.M. revealed a choice of cereal, cheese scrambled eggs, and toast. Interview on 12/30/25 at 7:59 A.M. with Resident #17 revealed she would eat cold cereal but not hot cereal. She indicated at times she was tired of eggs but today they were fine. Resident #17 reported she did not like cheese on her eggs. Interview 12/30/25 at 8:05 A.M. with Licensed Practical Nurse (LPN) #90 revealed everyone gets the same breakfast daily. LPN #90 confirmed she was going to get Resident #17 cold cereal since there was none on her tray. LPN #90 reported Resident #17 declined cereal when she was asked when she received her breakfast tray. Review of the Meal Identification and Preference Card Policy, undated, revealed a meal identification and food preferences card will be used properly identify each individual's needs including food and beverage preferences. 2. Review of Resident #43's medical record revealed the resident was admitted on [DATE] and readmitted on [DATE] with diagnoses including depression, Alzheimer's disease and weakness. Review of Resident #43's physician orders revealed orders dated 11/26/25 for a regular diet, mechanical soft texture with a thin consistency and a four ounce high calorie supplement. Review of Resident #43's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had moderate cognitive impairment. Resident #43 was not able to answer questions appropriately. Review of Resident #43's nutrition care plan revealed an intervention dated 12/05/25 for the diet as (continued on next page)		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ordered which included a regular diet, mechanical soft texture with thin liquids. Review of Resident #43's dinner meal ticket revealed a baked potato with butter only, chocolate pudding, grilled cheese and a chocolate mighty shake (nutritional shake). Review of Resident #43's meal ticket for breakfast 12/30/25 revealed beverages included eight ounces of 2% milk, four ounces of orange juice, eight ounces of water and the resident's preferences included four ounces of chocolate supplement with meals. Interview on 12/29/25 at 4:42 P.M. with Registered Dietitian (RD) #202 revealed the resident's daughter filled out the menus and the resident received a supplement with each meal. RD #202 confirmed the resident liked the chocolate flavored supplement and accepted the supplement at 100%. Observation on 12/29/25 at 5:00 P.M. revealed Resident #43's dinner tray consisted of grilled cheese, a cut up baked potato, orange juice, strawberry gelatin and two cookies. The resident did not have a mighty/nutritional shake on her tray and the chocolate pudding was missing from the tray. Interview on 12/29/25 at 5:05 P.M. with RD #202 confirmed Resident #43's meal tray did not have the chocolate pudding per the resident's preferences and daughter's request. Observation on 12/30/25 at 7:33 A.M. revealed Resident #43's meal tray consisted of oatmeal with brown sugar, scrambled eggs, toast and vanilla mighty/nutritional shake (not chocolate per preference). Interview on 12/30/25 at 7:45 A.M. with Speech Therapist (ST) #203 confirmed Resident #43 was supposed to have a chocolate mighty shake and she was served a vanilla mighty shake. Interview on 12/30/25 at 7:58 A.M. with Dietary Manager (DM) #74 confirmed Resident #43's preferences included four ounces of chocolate supplement with meals and chocolate pudding and the resident did not receive the chocolate supplement because the facility was out of chocolate mighty shakes. She added chocolate syrup to the mighty shake and stated the kitchen staff should have added chocolate syrup per the resident's preferences. Observation on 12/30/25 at 11:13 A.M. of facility lunch meal service revealed Resident #43's lunch tray had a strawberry flavored nutritional supplement delivered on her tray. Review of the tray ticket specified chocolate flavor was preferred for nutritional supplement. It was later observed DM #74 returned to the kitchen for a vanilla flavored nutritional supplement for Resident #43 that she added chocolate syrup to. Interview on 12/30/25 at 11:15 A.M. with DM #74 revealed the facility ran out of chocolate flavored nutritional shakes; however, had gotten them on the food delivery truck that day. DM #74 indicated the chocolate flavored supplements were still frozen that were delivered today. DM #74 indicated she would have expected the staff to honor the preference and add chocolate syrup to the vanilla supplement.		

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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 observation, record review, and interview, the facility failed to ensure appropriate enhanced barrier precaution signage was in place and appropriate isolation gowns were used when completing wound care. This affected two (#5 and #61) of three residents reviewed for pressure ulcer wounds. Findings include: 1. Review of the medical record for Resident #5 revealed an admission date of 11/06/15 and diagnoses included Alzheimer's disease, diabetes mellitus, idiopathic progressive neuropathy, venous insufficiency, obesity due to excess calories, generalized muscle weakness, oropharyngeal phase dysphagia, and anxiety disorder. Review of the Medicare Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #5 had Brief Interview for Mental Status (BIMS) score of 01 indicating severe cognitive impairment. Review of the physician's order dated 12/23/25 revealed order to cleanse open area to coccyx with normal saline (NS), pat dry, apply calcium alginate and cover with foam dressing daily and PRN. Review of wound care note dated 12/29/25 revealed Resident #5 was seen for an initial consultation of a wound. Resident #5 had an in-house acquired stage three pressure ulcer to the coccyx measuring 1.5 centimeters (cm) length by 0.6 cm width by 0.3 cm depth with moderate exudate. There was noted to be pink granulating tissue across the wound bed. Observation on 12/30/25 at 8:55 A.M. with Registered Nurse (RN) Wound Nurse #193 revealed RN Wound Nurse #193 was not wearing protective isolation gown while completing wound care to Resident #5's coccyx pressure wound. Interview on 12/30/25 at 9:01 A.M. with RN Wound Nurse #193 confirmed she did not wear a protective isolation gown while completing wound care to Resident #5's coccyx wound and confirmed the resident was not placed in enhanced barrier precautions with signage to indicate precautions were needed. 2. Review of Resident #61's medical record revealed the resident was admitted on [DATE] with diagnoses including nondisplaced bimalleolar fracture of the left lower leg, fibromyalgia and depression. Review of Resident #61's admission MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #61's pressure wound care plans revealed to apply skin prep daily and leave open to air daily on dayshift. Review of Resident #61's Wound Care progress note dated 12/22/25 at 10:15 A.M. revealed the resident had an unstageable pressure ulcer related to the cast/orthopedic brace to the left heel which measured 1.8 cm length by 1.5 cm width by undetermined depth with 100% eschar. The treatment orders included an order to cleanse with normal saline, apply skin prep and leave open to air. Observation on 12/30/25 at 8:48 A.M. with RN Wound Nurse #193 revealed she washed her hands, applied gloves and applied skin prep to the left heel. RN Wound Nurse #193 did not cleanse the left (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	heel first with normal saline and was not wearing protective isolation gown while completing the resident's wound care. Interview on 12/30/25 at 8:54 A.M. with RN Wound Nurse #193 confirmed she did not wear a protective isolation gown while completing the wound care to the resident's left heel and she confirmed the resident was not placed in enhanced barrier precautions with signage placed on the resident's door. Review of the Enhanced Barrier Precaution policy dated 2001 indicated enhanced barrier precautions (EBPs) were utilized to reduce the transmission of multi-drug-resistant organisms (MDROs) to residents. EBPs were indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. Wounds generally include chronic wounds such as pressure ulcers, diabetic foot ulcers, venous stasis ulcers, and unhealed surgical wounds.		