STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365936	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Retirement Community of Lima Inc	2440 Baton Rouge Avenue Lima, OH 45805

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interviews, and policy review, the facility failed to ensure staff notified the physician and family representatives of residents' changes in condition. This affected two (#24 and #51) of two residents reviewed for notification. The current census is 47.Findings include:1. Record review for Resident #24 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #24 include fracture of the pelvis, chronic pain, post-traumatic stress disorder, depression, epilepsy, and hypertension. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. Review of Resident #24's care plans dated 04/29/25 revealed a focus for cerebral vascular accident related to hypertension. Interventions include to monitor vital signs and notify medical doctor of significant abnormalities, give medications as ordered. Review of physician orders dated 11/21/25 revealed Resident #24 was to be administered clonidine 0.1 milligrams, (mg) tablet by mouth every 8 hours as needed for systolic blood pressure greater than 170. Review of Resident #24's vital signs dated from 11/2025 to 03/2026 revealed Resident #24 had on 02/27/26 a systolic blood pressure (SBP) of 171, on 02/22/26 SBP was 174, on 01/15/26 SBP was 206, and on 12/19/25 SBP was 219. Review of Resident #24's progress notes dated from 12/01/2025 to 03/12/2026 revealed there was no documentation of any notification to the physician of Resident #24's blood pressure being out of normal limits on 01/15/26 or 12/19/25. Interview on 03/09/26 at 9:00 A.M. and on 03/16/26 at 8:30 A.M. with Resident #24 revealed the resident stated he was concerned due to many times he felt his blood pressure was too high. Resident #24 stated staff are monitoring his blood pressure, but when he goes to see his cardiologist he is being told no one from the facility is reporting to the physician any abnormalities with his blood pressure. Interview on 03/12/26 at 2:00 P.M. with Director of Nursing, (DON) verified there was no documentation in Resident #24's medical records of the facility notifying the primary physician or cardiologist of Resident #24's high blood pressures. 2. Review of the medical record for Resident #51 revealed an admission date of 05/14/24 with (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnoses including diabetes mellitus, Down's Syndrome, Hirschsprung's disease, and morbid obesity. Resident #51 discharged to the hospital on [DATE] and did not return to the facility. Review of an annual Minimum Data Set (MDS) assessment, dated 05/18/25,indicated Resident #51 had severe cognitive impairment and was dependent upon staff for activities of daily living. Further review revealed a weight loss note dated 06/27/25 which stated Resident #51 had a significant weight loss. The note stated Resident #51's weight was 241 pounds on 02/05/25, 238 pounds on 04/02/25, and 183.7 pounds on 06/25/25. The medical record did not have documentation to support the facility notified the physician of Resident #51's significant weight loss. Interview on 03/16/26 at 10:34 A.M, with the Assistant Director of Nursing (ADON) #210 confirmed the medical record for Resident #51 did not have documentation supporting the facility notified the physician of the significant weight loss on 06/27/25. Review of the facility policy titled, Nutrition (impaired)/Unplanned Weight Loss, revised September 2017, stated staff would report to the physician any significant weight gains or losses or any abrupt or persistent change from baseline appetite or food intake. This deficiency represents non-compliance investigated under Complaint Number 2698450.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, census list review, observation, resident interview, staff interview, and review of facility policy, the facility failed to ensure residents were provided a clean and sanitary environment. This directly affected Resident #3 and potentially 14 additional residents (#2, #4, #9, #12, #13, #17, #21, #25, #33, #34, #35, #40, #42, #49) who resident on the same hall as Resident #3. The facility census was 47.Findings include:Review of the medical record revealed Resident #3 was admitted on [DATE]. Diagnoses included acute and chronic respiratory failure with hypoxia, type two diabetes mellitus with hyperglycemia, and chronic kidney disease stage 3.Review of the Minimum Data Set (MDS), dated [DATE], revealed the resident was cognitively intact and required set-up/clean up assistance with toileting, showering, and personal hygiene. Review of the care plan, revised on 10/01/25, revealed Resident #3 has mixed bladder incontinence. Interventions include to check frequently and as required for incontinence (wash, rinse, and dry perineum), apply barrier cream, and change clothing as needed after incontinence episodes, resident does not wear briefs, preference- encouraged resident to have chux pad then open brief in chair while up during the day to help contain incontinent episodes, and patient to let staff know if she needs assistance with changing when soiled. Observation on 03/09/26 during the initial tour revealed the 600 hall had a strong pervasive urine odor.Observation on 03/11/26 at 12:15 P.M. revealed upon entering the 600 hall there was a strong pervasive urine odor. Interview on 03/11/26 at 12:17 P.M. with Licensed Practical Nurse (LPN) #202 verified the odor was coming from Resident #3's room. Observation on 03/11/26 at 12:19 P.M. revealed Resident #3's room had a pile of laundry near the door. Consecutive interview with Resident #3 revealed every day she places soiled laundry on the floor near the door and an aide will collect them. Resident #3 stated the pile of laundry had been there since earlier this morning and when housekeeping came to clean additional soiled laundry in the room was added to the pile. Interview on 03/11/26 at 12:23 P.M. with Certified Nursing Assistant (CNA) #223 and CNA #282 verified the 600 hall was malodorous and verified the soiled clothing. CNA #223 and CNA #282 revealed there is a bagged soiled down comforter in Resident #3's room that she will not allow the facility to launder and is waiting for pick-up by a family member. Interview on 03/11/26 at 12:28 P.M. with CNA #256 verified the odor on the 600 hall, adding that it is always a problem. CNA #256 revealed some residents on the hall have asked to have their door shut due to the odor. CNA #256 stated she did not know the soiled linen was on the floor and would collect it.Interview on 03/11/26 at 12:35 P.M. with Resident #34 verified she likes her door shut and at times it is due to the odor in the hall.Interview on 03/11/26 at 12:55 P.M. with CNA #256 verified when she collected the laundry from Resident #3's floor the laundry was saturated.Review of the facility census list revealed 14 residents (#2, #4, #9, #12, #13, #17, #21, #25, #33, #34, #35, #40, #42, #49) resided on the same hall as Resident #3.Review of the policy titled, Homelike Environment, dated 2021, verified residents are provided with a safe, clean, comfortable, and homelike environment. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a homelike settings including pleasant, neutral scents. This deficiency represents non-compliance investigated under Complaint Number 2568764 and 2615090.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on medical record review, observation, staff interview, and review of facility policy, the facility failed to ensure residents were free from physical restraint. This affected one (#30) of one resident reviewed for phyiscal restraint. The facility census was 47. Findings include:Review of the medical record revealed Resident #30 revealed an admission date of 10/06/23. Diagnoses included unspecified dementia, hyperlipidemia, major depressive disorder recurrent, anxiety disorder, and cognitive communication deficit. Review of the Minimum Data Set (MDS) assessment, dated 02/02/26, revealed the resident is severely cognitively impaired and requires set-up/clean-up assistance with eating. Resident #30 is dependent for toileting, showering, and personal hygiene. Resident #30 had occasionally behaviors of physical aggression, verbal aggression, and other behaviors in addition to rejection of care and wandering. Observation on 03/11/26 at 10:34 A.M. revealed Resident #30 was alert in a wheelchair sitting at the dining room table. Resident #30's wheelchair was locked on the left side. Observation on 03/11/26 at 11:49 A.M. revealed Resident #30 at the dining room table eating lunch at the same location as the previous observation. Resident #30's wheelchair was noted to be locked on the left side. Interview on 03/11/26 at 2:22 P.M., with Certified Nursing Assistant (CNA) #279 verified Resident #30 is not able to lock or unlock her wheelchair. CNA #279 stated locking Resident #30's wheelchair was to ensure she remained at the table and does not wander throughout the facility during meals. CNA #279 verified the staff are not supposed to lock the wheelchair. Review of the undated facility policy titled, Abuse, Mistreatment, Neglect, Injuries of Unknown Source and Misappropriation of Resident Property, revealed the facility will not tolerate mistreatment, abuse, exploitation, or neglect of its residents or misappropriation of resident property by anyone. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This deficiency represents non-compliance investigated under Complaint Number 2698450.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on review of the medical record, staff interview, and policy review, the facility failed to develop a comprehensive person care plan related to skin impairment. This affected one (#10) of three residents reviewed for skin breakdown. The facility census was 47.Findings include:Review of the medical record for Resident #10 revealed an admission date of 09/04/25 with medical diagnoses of cerebral infarction with left hemiplegia, mood disorder, hypertension (HTN) and epilepsy. Review of a quarterly Minimum Data Set (MDS) assessment, dated 12/31/25, indicated Resident #10 had moderate cognitive impairment and required partial/moderate staff assistance with toilet hygiene, bathing and supervision with bed mobility and transfers. Review of the MDS revealed no skin issues were noted.Review of the medical record for Resident #10 revealed documentation on shower sheets dated 01/02/26, 01/07/26, 01/09/26, 01/16/26, 01/24/26, and 01/30/26 which stated Resident #10 was noted to have redness under bilateral breasts and to her groin area which had worsened. The shower sheets indicated lotion was applied. Review of documentation on shower sheet dated 02/04/26 stated redness still under her breasts, powder did not work, and had been this way for months; on 02/06/26, redness noted under breasts and groin area; and on 02/27/26, old redness noted to breasts, groin, and belly. Review of medical record for Resident #10 revealed a Wound Nurse Practitioner (NP) note dated 02/25/26 stated was resident was seen for initial evaluation and management of rash below breasts, in groin, umbilicus, and buttocks. The note stated nursing reported erythema to areas and odor. Observation of rash revealed fungal dermatitis noted to right inferior breast 16 centimeter (cm) by 13 cm, left inferior breast 7 cm x 10 cm, periumbilical 3 cm by 3 cm, and bilateral groin and buttocks with no measurements noted. The note stated Resident #10 was diagnosed with extensive fungal dermatitis to skin folds and buttocks.Review of the medical record revealed no documentation to support the facility developed a comprehensive person-centered care plan which addressed Resident #10's ongoing rash. Interview on 03/12/26 at 9:21 A.M. with MDS Nurse #201 confirmed Resident #10's medical record did not contain a comprehensive person-centered care plan to address Resident #10's ongoing rash or interventions in place to treat/prevent worsening of the rash.Interview on 03/12/26 at 10:00 A.M. with the Director of Nursing (DON) stated the expectation is for staff to complete skin assessments for residents weekly and document in the medical record. Review of the undated facility policy titled, Care Plan, comprehensive person-centered, stated a comprehensive person-centered CP that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on medical record review, observations, staff interview, and policy review, the facility failed to provide activities to meet the resident's needs and cognitive capabilities. This affected one (#40) of three residents reviewed for activities. The facility census was 47.Findings include: Review of the medical record for Resident #40 revealed an admission date of 09/29/20 with medical diagnoses of cerebral palsy (CP), profound intellectual disabilities, seizures, hypertension, and dysphagia. Review of an annual Minimum Data Set (MDS) assessment, dated 02/11/26, indicated Resident #40 had severe cognitive impairment and was dependent upon staff for all activities of daily living. Review of the medical record for Resident #40 revealed a care plan dated 01/23/24 that stated Resident #40 was dependent upon staff for emotional, physical, spiritual, creative, and community activities and social well-being related to CP and intellectual disabilities with a goal to maintain involvement in cognitive stimulation, and social activities as desired. Interventions included inviting Resident #40 to scheduled activities, to ensure the activities Resident #40 was attending were compatible with physical and mental capacities, adapted as needed, and compatible with individual needs and abilities. Further review revealed a care plan dated 01/23/24 which stated Resident #40 was dependent upon staff for emotional, physical, spiritual, creative, and community activities with a goal for Resident #40 to participate in room visit programming two to four times weekly. Interventions included monitor visits to determine length of a visit and provide sensory stimulating interventions. Review of an admission assessment note dated 02/04/26 included a quarterly activity note for Resident #40 which stated preferences and participating level this quarter are group and one-on-one activities. The note stated Resident #40 responds to music and staff would do one-on-one and hand massages. Review of Resident #40's activity documentation for January 2026 revealed hand massages on 01/02/26, 01/14/26, 01/28/26 and 01/29/26. Further review of January activity documentation revealed Resident #40's activity on 01/05/26, 01/08/26, 01/09/26, and 01/27/26 was to be sitting up in the living room. Resident #40 was noted to participate with room visit on 01/16/26 and 01/23/26 and small chat on 01/27/26. No other activities were documented for Resident #40 in January 2026. Review of Resident #40's activity documentation for February 2026 revealed hand massages were done on 02/04/26, 02/11/26, 02/18/26, 02/20/26, and 02/25/26. The documentation indicated Resident #40 was up in the living room on 02/09/26 and 02/16/26 and had room visit on 02/03/26. An activity was documented on 02/13/26 for Valentine Day party and on 02/27/26 that Resident #40 was up in her room listening to music. No other activities were documented for Resident #40 in February. Lastly, review of Resident #40's activities for March 2026 revealed hand massages on 03/04/26, 03/11/26, room visit on 03/06/26, and up in the living room on 03/11/26 and 03/12/26. No other activities were documented. Observation on 03/09/26 from 12:15 P.M. to 1:55 P.M. Resident #40 was observed sitting in a common area near the 400 Hall in front of a television. The observation revealed no staff interaction with Resident 40. Observation on 03/12/26 at 9:50 A.M. observed Resident #40 sitting in common area near the 400 Hall in front of the television. Other residents were observed sitting in the common area watching (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	television. No staff were noted to be present. Interview on 03/12/26 at 10:08 A.M. with Activity Director (AD) #207 confirmed the activity documentation from 01/01/26 to 03/09/26 did not have support Resident #40 was offered or provided activities as care planned for the residents preferences and needs. AD #207 confirmed the activity provided on some days included up in the living room which was the common area near the 400 Hall, up in her room with music on the television, and hand massages. Review of the facility policy titled, Activity, dated November 2017, stated the facility provides, based on the comprehensive assessment, care plan, and preferences of each resident, an on-going program to support residents in their choice of activities, both facility sponsored groups and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This deficiency represents non-compliance investigated under Complaint Number 2698450.

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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 medical record reviews, observation, and staff interviews, the facility failed to continually assess a surgical wound and schedule recommended follow up wound clinic appointments for Resident #02; failed to ensure accurate assessment of skin impairment and initiate treatment timely for a rash for Resident #10; and the facility failed to document the cause of wound injury/trauma area for Resident #51. This affected three (#02, #10, and #51) of four residents reviewed for skin assessments and treatments. The facility census was 47. Findings include: 1. Review of the medical record for Resident #02 revealed an admission date of 09/15/25, with medical diagnoses of acute osteomyelitis, diabetes mellitus (DM), peripheral vascular disease (PVD), congestive heart failure (CHF) and anemia. Review of the medical record revealed Resident #02 discharged to hospital on [DATE], readmitted to the facility on [DATE], discharged to the hospital on [DATE], readmitted to the facility on [DATE], discharged to the hospital on [DATE] and readmitted to the hospital on [DATE]. Review of the medical record for Resident #02 revealed a quarterly Minimum Data Set (MDS) assessment, dated 02/20/26, which indicated Resident #02 was cognitively intact and was dependent upon staff for toileting, bathing, and transfers, and required substantial/maximum staff assistance with bed mobility. The MDS did not contain documentation to support Resident #02 had a surgical wound. Review of the medical record for Resident #02 revealed a physician order dated 02/15/26 to cleanse the left heel with wound cleanser, pat dry, apply Oil Emulsion (petroleum gauze) to wound bed, cover with silicone bordered dressing to change three times per week and as needed. Review of the medical record for Resident #02 revealed an admission assessment dated [DATE] which stated Resident #02 had a DM ulcer to left heel. Review of admission assessment dated [DATE] stated Resident #02 had a pressure ulcer to left heel. Review of weekly skin observation dated 12/21/25 stated Resident #02 had surgical site to left heel, and admission assessment dated [DATE] did not have any documentation related to wound to left heel. Review of the weekly wound assessment dated [DATE] stated Resident #02 had a surgical site to left heel which measured 1 centimeter (cm) by 1 cm by 0.1cm. The assessment stated the left heel wound started as a DM ulcer on 09/15/25 and was debrided while Resident #02 was hospitalized from [DATE] to 12/03/25. The note stated the wound to Resident #02's left heel was now categorized as a surgical wound and had a moderate amount of serosanguinous drainage.Review of the medical record for Resident #02 revealed a Wound Clinic note dated 01/13/26 which stated Resident #02 had left heel wound for many months status post heel incision and drainage with skin graft and cerement G. The note stated the wound to the left heel was characterized as a pressure ulcer.Review of the medical record for Resident #02 revealed a physician order dated 02/15/26 to cleanse the left heel with wound cleanser, pat dry, apply Oil Emulsion (petroleum gauze) to wound bed, cover with silicone bordered dressing to change three times per week and as needed. Review of the medical record for Resident #02 revealed wound physician note dated 03/04/26 revealed no documentation to support the facility addressed left heel wound. Interview on 03/11/26 at 2:50 P.M., with Outpatient Wound Registered Nurse (OWRN) #304 at the Wound Clinic stated Resident #02 was last seen at the Wound Clinic on 01/13/26 for evaluation of left heel pressure ulcer with surgical site which measured 2.4 cm by 2.1 cm by 0.05 cm with sutures in place. OWRN #304 stated the Wound Clinic called the facility on 03/05/26 and left a message for a return call to schedule a follow-up appointment for Resident #02 but had not heard back from the facility. Observation on 03/11/26 at 3:00 P.M., of Wound Nurse #246 completed wound care for Resident #02's left heel. Wound Nurse #246 was observed to apply personal protective equipment (PPE) and removed the dressing dated 03/10/26 from Resident #02's left heel. Resident #02's left heel observed to have a 1 cm by 1 cm round wound with small amount of drainage noted. Wound bed was observed to be beefy red and surrounding skin was pink. No odors noted. Wound Nurse #246 was observed to completed dressing change as ordered and no concerns with wound care or infection (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	control observed.Interview on 03/11/26 at 3:05 P.M., with Wound Nurse #246 stated Resident #02 has had a wound to her left heel since admission on [DATE] and that the facility had not measured the left heel wound because the wound clinic was monitoring the wound. Wound Nurse #246 confirmed the facility completed treatments to left heel wound three times per week as ordered. Wound nurse #246 confirmed Resident #02 had not been seen by the wound clinic since 01/13/26 because of a hospitalization and a follow up appointment had not been made yet. Wound Nurse #246 confirmed Resident #02's left heel wound had not been measured from 01/13/26 until 03/11/26. 2. Review of the medical record for Resident #10 revealed an admission date of 09/04/25 with medical diagnoses of cerebral infarction with left hemiplegia, mood disorder, hypertension (HTN) and epilepsy. Review of the medical record for Resident #10 revealed a quarterly MDS assessment, dated 12/31/25, which indicated Resident #10 had moderate cognitive impairment and required partial/moderate staff assistance with toilet hygiene, bathing and supervision with bed mobility and transfers. Review of the MDS revealed no skin issues were noted. Review of the medical record for Resident #10 revealed documentation on shower sheets dated 01/02/26, 01/07/26, 01/09/26, 01/16/26, 01/24/26, and 01/30/26 which stated Resident #10 was noted to have redness under bilateral breasts and to her groin area which had worsened. The shower sheets indicated lotion was applied. Review of documentation on shower sheet dated 02/04/26 stated redness still under her breasts, powder did not work, and had been this way for months, 02/06/26 redness noted under breasts and groin area, and on 02/27/26 old redness noted to breasts, groin, and belly. Review of the weekly skin assessments dated 01/06/26, 01/16/26, 01/27/26, 02/10/26, and 02/20/26 stated Resident #02 had no skin issues noted. Review of a weekly wound observation dated 02/25/26 revealed Resident #10 had fungal areas under right and left breasts, and belly button. The observation did not include measurements and stated no open areas were noted.Review of Resident #10s physician orders revealed a physician order dated 12/31/25 for miconazole nitrate cream 2% to rash under breasts topically every shift for infection. The order was discontinued on 02/15/26 and a new order was written to cleanse under bilateral breasts with soap and water, rinse, pat dry, apply antifungal powder two times per day. Review revealed an order dated 02/25/26 apply antifungal cream to buttocks, 02/26/26 Diflucan (antifungal medication) 150 milligram (mg) one tablet by mouth daily for four days. and on 03/01/26 Benadryl 25 mg one tablet every eight hours as needed for itching. Review of medical record for Resident #10 revealed a Wound Nurse Practitioner (NP) note dated 02/25/26 which stated was seen for initial evaluation and management of rash below breasts, in groin, umbilicus, and buttocks. The note stated nursing reported erythema to areas and odor. Observation of rash revealed fungal dermatitis noted to right inferior breast 16 cm by 13 cm, left inferior breast 7 cm x 10 cm, periumbilical 3 cm by 3 cm, and bilateral groin and buttocks with no measurements noted. The note stated Resident #10 was diagnosed with extensive fungal dermatitis to skin folds and buttocks and an order was give for antifungal powder to skin folds and antifungal cream to buttocks, Diflucan 150 mg daily for five days. Review of the medical record for Resident #10 revealed a nurses note dated 03/02/26 at 7:02 P.M. which stated Resident #10's significant other requested to take Resident #10 to Urgent Care due to excoriation under breasts and new rash covering extremities and torso. Review of a nurse's note dated 03/02/26 at 9:53 A.M. stated Resident #10 returned to the facility with new orders for Keflex (antibiotic) and Diflucan for a fungal infection of the skin and candidal intertrigo. Review of the medical record for Resident #10 revealed an Urgent Care note dated 03/02/26 which stated resident presented with complaints of rash under bilateral breasts, umbilical area, under stomach, arms, and abdomen. The note stated examination of skin revealed rash was macular, papular, and purpuric with areas of erythema and excoriation under bilateral breasts, lower abdomen, and umbilical was sloughing. The note stated an order for Keflex and Diflucan were given.Review of Resident #10's physician orders dated 03/02/26, for fluconazole (Diflucan) 150 mg one tablet by mouth one day per week on Tuesdays, and an order dated 03/11/26 ketoconazole external cream 2% apply under breasts and groin topical every shift. Review of the medical record revealed no (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Retirement Community of Lima Inc	2440 Baton Rouge Avenue Lima, OH 45805

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation to support the facility administered Keflex as ordered by Urgent care on 03/02/26.Interview on 03/11/26 at 10:52 A.M. with Licensed Practical Nurse (LPN) #202 stated Resident #10's areas started as yeast areas under her breasts but have gotten worse. LPN #202 stated Resident #10 did not complain of pain but frequent itching. Interview and observation on 03/12/26 at 11:55 A.M., with Resident #10 stated the rash under her breasts, to her groin, and on her belly have been present for a long time and hasn't improved. Resident #10 stated the areas are very itchy but were not causing her pain. Observation of Resident #10's abdomen revealed red rash noted under bilateral breasts extending down her abdomen and scattered over her back. Rash appeared dry and no drainage noted.Interview on 03/12/26 at 9:13 A.M. with the Director of Nursing (DON) confirmed the weekly skin assessments completed in January 2026 and February 2026 did not contain documentation to support Resident #10 had a rash under bilateral breasts, groin area, or umbilical area until wound observation assessment was completed on 02/25/26. DON also confirmed that the medical record had no documentation to support a treatment was initiated for the rash to Resident #10's groin or umbilical area until 02/25/26. DON also confirmed the facility did not complete a comprehensive skin evaluation for Resident #10's rash until the resident was seen by Wound NP on 02/25/26. DON also confirmed the Keflex was not administered as ordered by Urgent Care.3. Review of the medical record for Resident #51 revealed an admission date of 05/14/24 with DM, Down's Syndrome, Hirschsprung's disease, and morbid obesity. Resident #51 discharged to the hospital on [DATE] and did not return to the facility. Review of the medical record for Resident #51 revealed an annual Minimum Data Set (MDS) assessment, dated 05/18/25, which indicated Resident #51 had severe cognitive impairment and was dependent upon staff for activities of daily living. The MDS indicated Resident #51 had an indwelling catheter. Review of the medical record for Resident #51 revealed a Wound NP note dated 06/02/25 stated Resident #51 had a non-pressure wound left sacrum, trauma/injury 3 cm by 0.2 cm with moderate serous exudate and 10% slough present. Further review revealed a Wound NP note dated 07/01/25 revealed Resident #01 continued with non-pressure to left sacrum, full thickness trauma which measured 0.5 cm by 0.5 cm by 0.2 cm with 10% slough and surgical debridement completed. Review of the medical record for Resident #51 revealed a physician order dated 06/17/25 to cleanse sacral wound with wound cleanser or normal saline, apply calcium alginate, and cover with bordered gauze daily and as needed. Review of the medical record revealed treatments were completed as ordered.Interview on 03/16/26 at 9:01 A.M. with MDS Nurse #201 confirmed the medical record did not have documentation to support what caused the trauma or what type of trauma was to Resident #51's sacrum. MDS Nurse #201 stated she was not able to determine what type of trauma Resident #51 had to his sacrum. This deficiency represents non-compliance investigated under Complaint Number 2568764 , 2615090 and 1335680.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 medical record review, observation, resident interview, staff interview, resident food list review, and review of facility policy, the facility failed to ensure resident meals were free from choking hazards. This affected Resident #34 with the potential to affect an additional seven (#3, #4, #8, #15, #21, #41, and #46) residents who were served soup. In addition, the facility failed to ensure the facility followed the fall policy and provided documentation of the fall in the medical record. This affected one (#6) of seven residents reviewed for falls. The facility census was 47.Findings include: 1. Review of the medical record revealed Resident #34 was admitted on [DATE]. Diagnoses included chronic obstructive pulmonary disease, heart failure, type two diabetes mellitus without complications, hypothyroidism, and major depressive disorder. Review of the Minimum Data Set (MDS) assessment, dated 12/07/25, revealed the resident was cognitively intact and set-up/clean-up for eating. Observation on 03/10/26 at 12:13 P.M. of Resident #34 ate lunch in her room with the door closed. Observation of the completed lunch meal revealed an approximate two inch chicken bone in the soup bowl. Subsequent interview with Resident #34 verified having chicken noodle soup and finding a chicken bone in the soup while eating. Interview on 03/10/26 at 12:29 P.M. with [NAME] #212 verified there was an approximate two inch chicken bone in Resident #34's soup bowl. Interview on 03/10/26 at 12:31 P.M. with Dietary Manager #226 revealed there was left over fried chicken from a recent meal and dietary staff deboned the chicken for the soup. Review of a facility provide resident list revealed on 03/10/26 eight (#3, #4, #8, #15, #21, #34, #41, and #46) were served chicken noodle soup for lunch. Review of policy titled, Purpose and Objectives of the Food and Nutrition Services Department, date 2021, verified the food will be prepared in a form to accommodate resident allergies, intolerances, and personal, religious, and cultural preferences based on reasonable efforts. Provided food and drink will be nutritious, palatable, attractive, and at a safe and appetizing temperature to meet individual needs. 2. Review of Resident #6's medical record revealed an admission date of 01/25/22. Diagnoses listed included chronic respiratory failure, obstructive sleep apnea, delusional disorders, and anxiety. Review of a quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #6 was cognitively intact and had two or more falls. Review of interdisciplinary team (IDT) notes dated 11/17/25 at 10:48 A.M., revealed a fall investigation was completed with interventions being reviewed. The note did not include any time or date of a fall, Resident #6's condition after the fall, or staff involved. Review of IDT notes dated 11/19/2025 10:48 A.M., revealed a fall investigation was completed with interventions being reviewed. The note did not include any time or date of any fall, Resident #6's condition after the fall, or staff involved. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of nurse's notes revealed no documentation of falls related to the IDT notes on 11/17/25 and 11/19/25. Review of Risk Management documents revealed Resident #6 had an unwitnessed fall on 11/14/25 and on 11/17/25. On the bottom of each Risk Management page, a statement was printed Privileged and Confidential - Not part of the Medical Record - Do not Copy. Interview with the Director of Nursing (DON) on 03/11/26 at 3:05 P.M. confirmed no documentation in nursing notes related to IDT notes dated 11/17/25 and 11/19/25. The DON stated those falls were documented in Risk Management and would not be able to be seen in the electronic medical record. During an interview on 03/16/2026 at 9:05 A.M., with the Assistant Director of Nursing (ADON) #210 confirmed per the facility's fall policy, a nurse should document a resident's fall in the nurse's notes. Review of the facility's policy titled Resident Falls, dated revised May 2023, revealed the nurse's notes should include head to toe assessment of the resident, the position observed, from bed or chair, in room, bathroom, etc, and what the resident was doing; transferring from bed to chair, attempting to walk to the bathroom, etc. Describe any injury observed; skin tear, laceration, bruising, swelling, limited range of motion, suspected fracture. This deficiency represents non-compliance investigated under Complaint Number 2698450 and 2568764.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the medical record review, hospital report review, staff interview and policy reviews, the facility failed to ensure the necessary care and treatment was provided when a resident with a urinary catheter displayed symptoms of a urinary tract infection (UTI). This affected one (#51) out of two residents reviewed for care and treatment of urinary catheters. The facility census was 47.Findings include: Review of the medical record for Resident #51 revealed an admission date of 05/14/24 with medical diagnoses of diabetes mellitus, down's syndrome, Hirschsprung's disease, and obstructive and reflex uropathy. Review of the medical record revealed Resident #51 was discharged from the facility on 07/06/25 to hospital for evaluation of ongoing right abdominal pain and was admitted to the hospital with peptic ulcer disease, cholecystitis and UTI. Review of Resident #51's annual Minimum Data Set (MDS) assessment, dated 05/18/25, indicated Resident #51 had severe cognitive impairment and was dependent upon staff for activities of daily living. The MDS indicated Resident #51 had an indwelling catheter. Review Resident #51's physician order dated 02/15/25 revealed an order for 16 French catheter to straight drain and catheter care every shift and as needed. Review of Resident #51's nurse's note, dated 04/09/25 at 2:27 P.M., documented the nurse noted purulent drainage from the catheter site when cleaning and a small amount of grey greenish drainage from the catheter. The note stated Resident #51 complained of pain where he peed. Review of Resident #51's physician orders revealed an order dated 04/11/25 for urinalysis (UA) with reflex culture. Review of the laboratory report dated 04/11/25 for a UA showed yellow and turbid (appears cloudy, hazy, or murky rather than transparent, often indicating the presence of substances like bacteria, pus, blood, or crystals) urine and positive for the presence of Hemoglobin, nitrates, white and red blood cells. Urine culture was ordered. Review of Resident 51's physician progress note dated 04/14/25 revealed the resident was seen for UA concerning UTI, starting antibiotic and no other complaints. Review of Resident #51's nurse's note dated 04/16/25, documented Resident #51's indwelling catheter was changed per monthly schedule. Review of the laboratory report for Resident #51 revealed UA culture result dated 04/16/25 was positive for greater than 100,000 pseudomonas and noted on the paper copy of the culture results was a handwritten physician order for Bactrim Double Strength (DS) two times per day for seven days. The undated note had an illegible physician or Nurse Practitioner (NP) signature. Review Resident #51's physician notes dated 04/22/25 and 04/30/25 revealed no documentation to support urinary status were addressed. Review Resident #51's medication administration record (MAR) for April 2025 revealed no documentation to support the facility administered the Bactrim or any other antibiotic. Review of the monthly Nurse Practitioner (NP) note, dated 05/19/25, revealed no documentation to support urinary status was addressed. Review of a nurse's note dated 05/23/25 at 5:30 A.M, documented Resident #51 yelled out that he couldn't pee. The note documented that the nurse observed Resident #51's catheter had no output, his abdomen was distended and hard upon palpation, and the Certified Nurse Assistant (CNA) reported Resident #51 had not had any urine output the entire shift. The note stated the nurse removed the old foley catheter and Resident #51 had large green foul-smelling discharge come from the penis. The note continued to state a new indwelling catheter was inserted under sterile technique and 500 cubic centimeters (cc) of dark odorous urine was returned. The note indicated a culture was collected. Review of Resident #51's medical record revealed no documentation of the physician being notified of the resident displaying symptoms of a potential UTI or having decrease urinary output. Review of Resident #51's physician orders revealed an order dated 05/23/25 for culture of genital. There were no orders to obtain laboratory work for the urinary tract infection symptoms. Review of the laboratory report for Resident #51 revealed the 05/23/25 genital culture came back with normal flora. Review of Resident #51's medical record revealed no documentation of the doctor being notified of the (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	symptoms on 05/23/25 or the resident being transferred to the hospital or the reason for the transfer on 05/28/25. Review of Resident #51's emergency room notes dated 05/28/25 documented Resident #51 was diagnosed with atypical pneumonia, UTI, and gastroesophageal reflux disease and ordered Levofloxacin 500 mg one tablet by mouth daily for 10 days. Review of Resident #51's nurses note dated 05/28/25 documented Resident #51 arrived back to the facility by emergency medical transport and Resident #51 had been diagnosed with UTI, pneumonia, and acid reflux. Review of Resident #51's physician order revealed an entry order dated 05/29/25 for Levofloxacin 500 milligram (mg) one tablet by mouth at bedtime for 10 days. Review of May 2025 MAR revealed the Levofloxacin was started on 05/29/25 given for the ten days. Review of Resident #51's nurse's note dated 06/11/25, documented resident's mom had concerns with resident's care. The note stated mom was going to have evaluation done for Hospice or palliative care. Stated the physician was notified and orders for UA, Complete Blood Count (CBC) and ultrasound (US) of right abdomen and medication changes noted. UA was obtained on 06/14/25 and culture returned on 06/16/25 which showed Methicillin- Resistant Staphylococcus Aureus (MRSA). Review of the laboratory report dated 06/11/25 for a UA showed yellow excessive turbid (appears cloudy, hazy, or murky rather than transparent, often indicating the presence of substances like bacteria, pus, blood, or crystals) urine and positive for the presence of Hemoglobin, nitrates, white and red blood cells. Urine culture was ordered. Review of the laboratory report dated 06/14/16 revealed the presence of MRSA and resistant to certain medications and susceptible to others. Review of the physician orders revealed order dated 06/27/25 for Macrobid 100 milligram (mg) one capsule by mouth two times per day for seven days. The medication was administered. Interview on 03/17/26 at 11:10 A.M. with MDS Nurse #201 confirmed the facility staff did not administer Bactrim as ordered in April 2025 for UTI. MDS Nurse #201 confirmed the facility did not obtain orders for repeat UA's to be completed in April or May 2025. MDS Nurse #201 confirmed there is no evidence of the physician being notified of the symptoms of the UTI or that the facility did not request an order for an UA to be done when resident was showing signs and symptoms of a possible UTI on 05/23/25. MDS Nurse #201 confirmed Resident #51 was diagnosed with UTI at the hospital on [DATE]. Review of the facility policy titled, Urinary Catheter Care, revised September 2014 stated the purpose was to prevent catheter-associated urinary tract infections (UTI). stated the staff were to observe the residents' urine level for noticeable increases or decreases. Stated if the levels stay the same, or increases rapidly, report it to the physician or supervisor. Review of the facility policy titled, Change of Condition dated May 2017 stated staff are expected to identify and report a change in a resident's baseline mental, behavioral, or physical status to a nurse. The nurse would assess the resident's condition based on the information reported. Emergency care for the resident would be provided if appropriate and /or necessary, the physician would be notified if warranted, emergency services would be contacted for transport if warranted, and the responsible party would be notified of a change in mediation or treatment or if the resident was transferred for acute care. This deficiency represents non-compliance investigated under Complaint Number 2615090 and 2575850.

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, Emergency Medical Services (EMS) report review, hospital documentation review, death certificate review, resident interview, staff interview, review of facility's policy for Cardio-Pulmonary Resuscitation (CPR), and review of facility's policy and procedure for In Case of Decannulation, the facility failed to ensure the necessary life-sustaining respiratory services were provided to residents who required invasive mechanical ventilation via tracheostomy (a hole in the front of the neck and into the windpipe) cannula. This resulted in Immediate Jeopardy and serious life-threatening harm on [DATE] at 1:40 A.M., when Resident #54 was found unresponsive without a pulse, with the tracheostomy cannula dislodged, and had been without oxygen for an unknown period of time. Staff were not trained in regards to reinserting the cannula or the procedure required to provide life-saving measures. Consequently, lifesaving CPR was not properly performed when Resident #54 was not provided with supplemental oxygen or re-cannulated timely, was transferred to the hospital and subsequently passed away three days later from an anoxic brain injury secondary to hypoxic respiratory failure. This affected one (Resident #54) of four residents reviewed for tracheostomy care. The facility identified two current residents with tracheostomies. The facility census was 47. On [DATE] at 12:13 P.M., the Administrator, the Director of Nursing (DON) and Chief Compliance Officer (CCO) #300 was notified Immediate Jeopardy began on [DATE] at 1:40 A.M. , when the an agency nurse, Licensed Practical Nurse (LPN) #288, was alerted by Certified Nurse Aide (CNA) #265 that while she was providing care for Resident #54 the tracheostomy (trach) had become de-cannulated and was no longer in place in the resident's trachea. LPN #288 went to assess Resident #54 and found the resident unresponsive with the tracheostomy cannula lying on her chest. LPN #288 attempted to place the tracheostomy cannula back into Resident #54's trachea and was unsuccessful. LPN #288 instructed CNA #265 to call Respiratory Therapist (RT) #236 for instruction and to call for Emergency Services (911). LPN #288 was unable to obtain a pulse on Resident #54 and began chest compression but did not apply any supplemental oxygen to the resident, who required mechanical ventilation to breathe. On [DATE] at 1:51 A.M., 11 minutes after the resident was found to be de-cannulated, unresponsive and without a pulse, RT #236 arrived at the facility along with Emergency Medical Services (EMS) and was able to re-cannulate the resident. After re-cannulating Resident #54's tracheostomy, RT #236 prepared the Ambu-bag (a hand-held, self-inflating device used to provide positive pressure ventilation to patients who are not breathing) with oxygen and began to supply oxygen to Resident #54 via the tracheostomy cannula. EMS assumed CPR chest compressions from LPN #288 and was able to reconnect the ventilator to Resident #54 and transport her to the hospital. While EMS was able to adequately ventilate Resident #54, the resident continued to require CPR measures at the hospital. Once a pulse was obtained, the resident was admitted to the Intensive Care Unit but was found to be non-reactive and in a vegetative state. Resident #54 passed away three days later, on [DATE], with the cause of death determined as anoxic brain injury (brain deprived of oxygen causing rapid cell death within minute), secondary to hypoxic (a dangerous condition where tissue receives insufficient oxygen to maintain homeostasis) respiratory failure. Immediate Jeopardy was removed on [DATE], when the facility implemented the following corrective actions: On [DATE], Resident #54 was transferred to the hospital. On [DATE] at 6:00 A.M., Respiratory Therapist Manager (RTM) #242 verbally in-serviced both agency nurses, LPN #288 and LPN #302. Both nurses returned demonstration and reviewed printed policies and procedures in the agency binder after the incident occurred. This education included suctioning (both open and closed), how to measure the placement of the suction catheter, decannulation, how to use Ambu-bag and the competency checklist for respiratory nursing care for residents on ventilators and residents who have tracheostomy and the location of crash carts and Automated External Defibrillator (AED). On [DATE], CCO #300 and former Human Resource Manager (HRM) #303 in-serviced RNs and LPNs on Respiratory policies, CPR, (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	supplemental oxygen, Trach and Decannulation. Policies and procedures were sent to all nurses via text message for immediate review. There was no documentation of receipt of the text to the staff. On [DATE], CCO #300 and former HRM #303, in-serviced CNAs on personal care for residents with tracheostomies. Policies and procedures were sent to all CNAs via text for immediate review. There was no documentation of receipt of the text to the staff On [DATE] at 10:30 A.M., the Administrator and CCO #300 educated RTM #242 on the facility's requirements for nurses training for ventilator dependent residents, supplemental oxygen, tracheostomy care and emergency procedures. On [DATE] at 10:30 A.M., RTM #242 implemented an education binder to track and audit all facility and agency staff education documents. Beginning on [DATE] at 10:30 A.M., RTM #242 or designated Respiratory Therapist will train agency nursing staff on ventilator dependent residents care plans, protocols for tracheostomy care and emergency procedures for ventilator dependent and/or trach residents prior to providing care to residents. Competency checklist to be completed by Respiratory Therapist. This is a new standard practice going forward without an end date. On [DATE] at 10:45 A.M., RTM #242 re-educated and completed check-off on Competency Checklist for Respiratory Care for Nursing, Decannulation and Emergency Procedures for Registered Nurses (RNs) and LPNs. Education/Training included verbal, return demonstration and printed procedures. This was completed on [DATE]. On [DATE] at 12:30 P.M., a Quality Assurance (QA) meeting was held immediately following notification of Immediate Jeopardy. This included CCO #300, the Administrator, LNHA, DON, Assistant DON, Minimum Data Set (MDS) Nurse, RTM #242, Infection Preventionist/Wound Nurse, Scheduler, Business Office Manager, Social Services, Activity Director, Maintenance Director, Dietary Manager, Therapy Manager, Housekeeping/Laundry Supervisor who met to discuss the [DATE] incident, education needed, policies and procedures to put into place. Beginning on [DATE] at 12:45 P.M., RTM #242 will complete a respiratory assessment for all at risk residents and ensure that residents are provided with respiratory care by trained staff. Completed by [DATE] at 4:00 P.M. Beginning on [DATE] at 1:30 P.M., the Director of Nursing (DON) and RTM #242, uploaded the acknowledgement procedure electronically to the Clipboard staffing agency to notify agency employees that our facility has vent/trach residents that require care outside of normal routine care. Agency staff must be trained by an RT on ventilator dependent resident care plans, protocols for tracheostomy care and emergency procedures for ventilator dependent residents and read and sign the Agency Nurse Binder at the nurse's station before starting their shift. This training will include verbal, return demonstration and printed procedures. Acknowledgement must be signed before the facility job positing applications will allow agency staff to pick up a shift at facility. DON verified posting on [DATE] at 8:05 P.M. On [DATE] at 3:00 P.M., RTM #242 completed Competency checklist and decannulation training for tracheostomy residents with Liberty Dialysis nurses. Training included verbal, return demonstration and printed procedures for respiratory needs of residents with tracheostomies. Completed on [DATE]. Beginning on [DATE], LPN Scheduler #255, DON, and RTM #242 will attempt to schedule at least one facility licensed nurse trained by respiratory therapist per shift. LPN Scheduler #255 will notify DON and RTM #242 of any shifts that do not have a facility nurse trained by RT. In the unplanned event the facility would have two agency nurses working, the facility will have RT coverage or another licensed facility nurse in the facility who has completed training with a Respiratory Therapist for the duration of the shift. This will be ongoing practice, unless there are no residents with vents/traches in the facility. Any resident who has a tracheostomy or ventilator needs to be considered for admission will not be admitted to the facility until an RT is present in facility. No ventilator or tracheostomy residents will be admitted off-hour or on the weekends if RT is not available. Beginning on [DATE], the DON or designated nurse manager and RTM #242 or designated Respiratory Therapist will monitor schedule daily to ensure scheduling compliance with RTs and agency staff. Beginning on [DATE], the RTM #242 or designated Respiratory Therapist will monitor agency education binder daily to ensure all education documents are completed. This will be ongoing. Beginning on [DATE], the DON or designated nurse manager will audit the education binder (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Retirement Community of Lima Inc	2440 Baton Rouge Avenue Lima, OH 45805

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	weekly to ensure that a Respiratory Therapist has trained all facility and agency staff. This will be ongoing. Beginning on [DATE] at 1:45 P.M, during the monthly Quality Assurance and Performance Improvement (QAPI) meeting with the Medical Director, a review of correction plan to ensure the training has been completed for all RNs, LPNs, agency and will be ongoing as needed. This will be reviewed at the quarterly QAPI meeting starting [DATE] and ongoing if the facility has residents that are ventilator dependent or have tracheostomy. Respiratory Department will provide additional training as needed outside of the regularly scheduled trainings. Beginning [DATE] and ongoing monthly, RTM #242 or the designated Respiratory Therapist will attend the monthly nurse and CNA meetings to provide ongoing education, review competency checklist and to ensure that all staff are knowledgeable of policies and procedures related to residents on life sustaining mechanical devices and/or requiring CPR. This training will include verbal, return demonstration and printed procedures. Although the Immediate Jeopardy was removed on [DATE], the deficiency remains at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is in the process of implementing their corrective action plan and monitoring to ensure on-going compliance.Findings include: Record review revealed Resident #54 was admitted on [DATE] and was discharged on [DATE]. Diagnoses included acute and chronic respiratory failure, dependence of a ventilator, obstructive sleep apnea, pulmonary hypertension, and malnutrition. Review of Resident #54's Minimum Data Set (MDS) comprehensive quarterly assessment dated [DATE] revealed the resident had intact cognition, no behaviors, and was receiving invasive ventilation via a tracheostomy cannula. Review of Resident #54's physician orders dated [DATE] revealed she was a Full Code, with a size 16 Shiley cannula with ventilator settings of Assist Control (AC) Respiratory Rate (RR) 12, Positive End-Expiratory Pressure (PEEP) 6, Tidal Volume (Vt) 400, and oxygen titrate to keep saturation at 90 percent. Review of Resident #54's care plans dated [DATE] revealed a focus for tracheostomy related to respiratory failure. Interventions included ensure trach ties are secured at all times, monitor and document restlessness and agitation, monitor respiratory rate, ventilator setting per order with oxygen via the tracheostomy/ventilator. Cannula (tube) out procedure: keep extra trach cannula and obturator (a structure that blocks or closes an opening) at the bedside, if cannula is coughed out, open stoma with hemostat. If cannula cannot be reinserted, monitor/document for signs of respiratory distress, if able to breathe spontaneously elevate head of bed 45 degrees, stay with resident and obtain medical help immediately. Review of the Emergency Medical Service (EMS) care report dated [DATE], revealed a call was reported as received from the facility at 1:44 A.M. EMS was dispatched to the facility, at 1:48 A.M. The EMS arrived at the facility at 1:49 A.M. and arrived at Resident #54's room. At 1:49 A.M., EMS documented the resident's tracheostomy cannula came out, facility staff were able to replace the trach cannula, and Resident #54 was loaded onto a cot and transported to the hospital. Per the EMS care report the staff at the facility were unable to provide any history or information about Resident #54 and no packet containing information was transferred with the patient to the hospital. EMS documented staff reported it was unknown how long the tracheostomy cannula was out of place. Review of the hospital documentation dated [DATE] at 2:09 A.M. revealed Resident #54 arrived at the emergency room by EMS transport. Resident #54 was evaluated for cardiac arrest secondary to hypoxic respiratory failure. Resident #54 had her trach (cannula) pulled out for an undisclosed amount of time. Per the hospital documentation the trach was replace and EMS did Advanced Cardiac Life Support (ACLS) with compression and ventilation prior to arrival. Upon arrival Resident #54 was in asystole (without a heartbeat) and required additional ACLS CPR measures to obtain a cardiac rhythm. Review of the Medical Decision Making section of the report ACLS algorithm was followed to initiate chest compression and medication to stabilize resident. Initial blood gas tests showed the resident had respiratory acidosis (lower than normal blood pH caused by hypoventilation) and it was anticipated that the hypoxic respiratory failure caused cardiac arrest. The hospital physician documented given a clear story of trach dislodgement the focus on respiratory failure as a primary cause for the cardiac arrest. Review of Resident #54's progress (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	notes dated [DATE], entered at 3:36 A.M. for care at 1:15 A.M., revealed LPN #288 documented this nurse was located at the nurse's station at time of incident. LPN #288 was alerted by CNA #265, Resident#54's trach had dislodged from the trachea while giving the resident care. LPN #288 immediately attempted to reinforce the tracheostomy cannula back into the trachea. LPN #288 simultaneously instructed the CNA #265 to call emergency service, and RT #236 for assistance, while attempting replacement of the cannula. RT stated she would come STAT (immediately). LPN #288 immediately began chest compression while awaiting the arrival of assistance. RT #236 arrived in eight to ten minutes along with EMS. RT #236 was able to locate the trach pathway and successfully reinsert the tracheal cannula back into trachea, as EMS was establishing vitals. Resident #54 was transferred out to the hospital. LPN #288 faxed over resident's medication summary and profile to hospital. LPN #288 contacted resident's husband with no answer, left voicemails, and notification of transfer. DON notified, LPN #288 awaiting report from hospital. Review of Resident #54's critical care note dated [DATE] at 6:51 A.M., revealed the Assessment and Plan section included cardiac arrest likely secondary to hypoxic respiratory failure after resident was found unresponsive at the facility for an unknown period of time and found to have dislodged trach. Concern for anoxic brain injury secondary to the cardiac arrest as the resident is not responding at this time with no withdrawal from pain.Review of Respiratory Care Note dated [DATE] at 2:22 P.M., documented by RT #236, called by facility at 1:40 A.M, because the ventilator was alarming and the tracheostomy looked weird. It was noted Resident #54 was completely decannulated. Trach was easily replaced and the resident was back on the ventilator. Resident #54 was very dusky, letting the ventilator carry her with a faint pulse. EMS was unable to get a blood pressure. EMS transferred the resident to gurney and to hospital. Review of Resident #54's death certificate dated [DATE] revealed the primary cause of death was anoxic brain injury secondary to cardiac arrest and hypoxic respiratory failure. During an interview on [DATE] at 9:37 A.M., Resident #24 stated he knew of a resident on a ventilator who had passed away due to the staff working not being trained on how to take care of residents on ventilators. Resident #24 said he heard a commotion one night and it was the EMS and staff talking about how the nurse who assigned to residents on ventilators did not know how to care for them properly. Resident #24 stated he knew there were no respiratory therapists in the building at night. During an interview on [DATE] at 1:25 P.M., RT #236 stated she worked in the facility on [DATE] from 6:00 P.M. to 12:00 A.M. On [DATE] around 11:00 P.M. she provided nighttime respiratory care for Resident #54 which included trach care, ventilator checks, and oxygen checks. RT #236 stated at the time she provided the care Resident #54 was in no distress, the trach was in place, the resident had no secretions, and her oxygen level was around 98 percent. RT #236 stated prior to her clocking out at 12:00 A.M. She asked LPN #288 if she was comfortable caring for Resident #54, as she was an agency nurse who had not worked on the unit before. RT #236 stated LPN #288 had told her, I am good and RT#236 left the facility. RT #236 stated on [DATE] early in the morning she was called by agency nurse LPN #288 and was told Resident #54's trach looked weird. RT #236 stated she asked the nurse simple questions about Resident #54's respiratory status and the only answers LPN #288 gave was saying I don't know. RT #236 stated she told the nurse to call 911 and she would be coming into the facility immediately. RT #236 stated on the phone she asked LPN #288 if the resident had a pulse, was breathing, and what happened to the trach, the only answer LPN #288 gave her was, I don't know. RT #236 stated when she arrived at the facility the EMS were coming into the building. RT #236 stated she led the EMS to the resident's room and reached the resident at 1:51 A.M. RT #236 stated LPN #288 was doing chest compression but was not providing any oxygen via the Ambu-bag or by any other means. RT #236 stated she was able to reinsert the trach cannula and she herself got the Ambu-bag out of the basket located on the vent, in the room. RT #236 stated she hooked it up to the oxygen tank, attached it to Resident #54 and started to supplement the oxygen via the Ambu-bag through the trach. RT #236 stated while she was preparing the Ambu-bag, EMS took over chest compressions and was asking LPN #288 questions about the resident in which LPN #288 kept (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	answering, I don't know where anything is for this resident. RT #236 stated she assisted the EMS with transferring the resident to a gurney and she hooked up the ventilator and assisted EMS to transfer the resident out of the facility on the ventilator. RT #236 stated she then went back to talk to the LPN #288 about the incident, but LPN #288 continued to tell her she did not know where anything was and how to care for the resident's trach when they become dislodged. During an interview on [DATE] at 10:00 A.M., CCO #300 revealed after the [DATE] incident with Resident #54 the CCO #300 did send education to the former Human Resource Manager #303 to have all facility nurses review the policies and procedures for tracheostomy care. CCO #300 stated she did not require signatures for the education, so she was unsure who received the education. During an interview on [DATE] at 9:33 A.M., agency nurse LPN #288 stated she had not worked in the facility with the ventilator residents prior to [DATE]. LPN #288 stated upon her arrival at the facility, on [DATE], from 6:00 P.M. to 6:00 A.M. shift, she was not oriented to the unit, received no resident orientation regarding care plans, and did not receive education or orientation on location of emergency equipment including the crash cart and emergency supplies in Resident #54's room. LPN #288 stated she had no experience in re-cannulating tracheostomy cannulas after they became dislodged and received no education from the facility on what to do if decannulation happens. LPN #288 stated she was led to believe by staff there would be a respiratory therapist in the building for the whole shift. LPN #288 stated on [DATE], she administered nighttime medications, sometime around 11:00 P.M. to Resident #54 and the resident was in no distress. LPN #288 stated she could not recall having any conversation with RT #236 prior to RT #236 leaving for her shift. LPN #288 stated she could not recall the ventilator alarming but stated in the early morning CNA #265 came to her at the nurse's station and said, Resident #54's trach came out. LPN #288 stated she immediately ran to the resident's room and found her trach laying on her chest. LPN #288 stated she tried to reinsert the trach into the resident's trachea but could not get the cannula back in. LPN #288 stated she then told the CNA #236 to call RT #236 and put her on speaker phone. LPN #288 stated she also told the CNA #236 to call for the other agency LPN #302 and 911, when she noticed Resident #54 was not breathing and was not responding to her. LPN #288 stated she continued to attempt to reinsert the trach cannula and then she started chest compressions on the resident when she could not obtain a pulse. LPN #288 stated it was a short time later RT #236 came back into the facility to the resident's room with EMS and RT #236 took over care of the resident by reinserting the trach cannula and then getting the Ambu-bag hooked up to oxygen. LPN #288 verified at no time from the time she found Resident #54 with her cannula out to the time RT #236 arrived at the resident's bedside was LPN #288 able to supply any oxygen to Resident #54. Per LPN #288 she did not know where the crash cart or the Ambu-bag was in the facility. LPN #288 verified she did have a current CPR certification at the time of the incident. During an interview on [DATE] at 2:57 P.M., Respiratory Therapy Manager (RTM) #242 stated respiratory therapists are scheduled for all day shifts from 6:00 A.M. to 6:00 P.M. and some night shifts but due to census may not be scheduled for a whole 12-hour shift, 6:00 P.M. to 6:00 A.M. RTM #242 stated on [DATE], RT #236 was told to clock out at 12:00 A.M. per the schedule. RTM #242 stated it was the facility's unwritten protocol for the RT to ask the nurses working on nightshift if they were comfortable taking care of the ventilated residents prior to the RT leaving the facility. RTM #242 stated it was reported to her LPN #288 told RT #236 she was fine taking care of Resident #54 when RT #236 left the facility. RTM #242 verified there was no official training for agency nurses on caring for residents with tracheostomy on the ventilators but stated it was in the care plans on what to do if the resident becomes decannulated. During an observation on [DATE] at 8:28 A.M. Resident #08 was dependent on a ventilator supplying support via a tracheostomy cannula. There was an Ambu-bag, extra suction wand, extra tracheostomy cannula, and emergency supplies located in a grey basket attached to the resident's ventilator. During an observation on [DATE] at 8:40 A.M, a crash cart was located outside of Resident #08's room in the hallway, painted red and clearly visible from the hallway on both sides. Emergency supplies were observed on the crash cart including an Ambu-bag, oxygen tank, suction (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	wands, and emergency tubing. Review of the facility policy titled Emergency Procedures - Cardio-Pulmonary Resuscitation, revised February 2018, revealed when a resident is found unresponsive assess for absence of breathing. If a cardiac arrest is likely the rescuer will begin CPR. Following the initial assessment begin with chest compressions, after 30 chest compressions provide 2 breaths via the Ambu-bag or manually with a CPR shield. All rescuers trained in CPR should provide ventilations with a compression to ventilation ratio of 30:2. Review of the policy titled, In Case of Decannulation, undated, the policy stated call 911 and call for a crash cart. Attempt to re-insert trach or establish an airway by covering the stoma with gauze and tape, in the gray basket on vent cart. Put on appropriate oxygen device if spontaneously breathing (in bag with spare trach on vent cart). If no spontaneous breaths begin Ambu-bag with face mask at 15 liters of oxygen with 100% O2 (oxygen), located in each room with a ventilator/trach on the vent stand and tank is already turned on, turn flow liter to 15. Check all vitals, if no pulse, begin compression and continue CPR unless indicated otherwise. This deficiency represents noncompliance investigated under Complaint Numbers 2724849, 2698450, 2615090, and 1335680.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews, staff interviews, and policy review, the facility failed to ensure residents were free from significant medications errors. This affected four (#3, #10, #51 and #53) residents out of five residents reviewed for medication administration. The facility census was 47.Findings include:1. Review of the medical record for Resident #10 revealed an admission date of 09/04/25 with medical diagnoses of cerebral infarction with left hemiplegia, mood disorder, hypertension (HTN) and epilepsy. Review of a quarterly MDS assessment, dated 12/31/25, which indicated Resident #10 had moderate cognitive impairment and required partial/moderate staff assistance with toilet hygiene, bathing and supervision with bed mobility and transfers.Review of a nurses note dated 03/02/26 at 7:02 P.M. stated Resident #10's significant other requested to take Resident #10 to Urgent Care due to excoriation under breasts and new rash covering extremities and torso. Review of a nurse's note dated 03/02/26 at 9:53 A.M. stated Resident #10 returned to the facility with new orders for Keflex (antibiotic) and Diflucan for a fungal infection of the skin and candidal intertrigo. Review of an Urgent Care note dated 03/02/26 stated Resident #10 presented with complaints of rash under bilateral breasts, umbilical area, under stomach, arms, and abdomen. The note stated examination of skin revealed rash was macular, papular, and purpuric with areas of erythema and excoriation under bilateral breasts, lower abdomen, and umbilical was sloughing. The note stated an order for Keflex and Diflucan were given.Review of the medical record for Resident #10 revealed no documentation to support the facility administered Keflex as ordered by Urgent care on 03/02/26.Interview on 03/12/26 at 9:13 A.M. with Director of Nursing (DON) confirmed the medical record did not have documentation to support Keflex was administered as ordered by Urgent Care. 2. Review of the medical record for Resident #51 revealed an admission date of 05/14/24 with DM, Down's Syndrome, Hirschsprung's disease, and morbid obesity. Resident #51 discharged to the hospital on [DATE] and did not return to the facility. Review of an annual Minimum Data Set (MDS) assessment, dated 05/18/25, indicated Resident #51 had severe cognitive impairment and was dependent upon staff for activities of daily living. The MDS indicated Resident #51 had an indwelling catheter. Review of Resident #51's nurse's note, dated 04/09/25 at 2:27 P.M., documented the nurse noted purulent drainage from the catheter site when cleaning and a small amount of grey greenish drainage from the catheter. The note stated Resident #51 complained of pain where he peed.Review of Resident #51's physician orders revealed an order dated 04/11/25 for urinalysis (UA) with reflex culture.Review of the laboratory report for Resident #51 revealed UA culture result dated 04/16/25 was positive for greater than 100,000 pseudomonas and noted on the paper copy of the culture results was a handwritten physician order for Bactrim Double Strength (DS) two times per day for seven days.Review Resident #51's medication administration record for April 2025 revealed no documentation to support the facility administered the Bactrim. Interview on 03/16/26 at 9:01 A.M. with Minimum Data Set (MDS) nurse #201 confirmed Resident #51 was not administered Bactrim as ordered in April for urinary tract infection.Review of the facility policy titled, Medication Administration, medications would be administered by legally-authorized and trained personas in accordance to application State, Local, and Federal laws and consistent with accepted standards of practice. 3. Review of Resident #53's closed medical revealed and admission date of 09/27/24. Diagnoses listed included breast cancer, hypertension, major depressive disorder, and osteoarthritis. Resident #53 was discharged on 08/19/25.Review of a quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #53 was cognitively intact.Review of outpatient oncology appointment documentation revealed on 06/26/25, Verzenio (breast cancer medication) 150 milligrams (mg) by mouth (PO) twice daily was ordered. A prescription dated 06/26/25 was included.Review of a nurse's note dated 07/02/25 at 2:13 P.M. revealed Resident #53 stated she was supposed to be on a new medication from oncology, but the nurse did not see any orders. The oncology office was called and a message was left.Further review of progress notes (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed no documentation of any follow-up or correspondence with outpatient oncology regarding Verzenio.Review of outpatient oncology appointment documentation dated 07/10/25 revealed Resident #53 had yet to receive Verzenio.Review of physician orders revealed Verzenio 150 mg PO twice daily for cancer treatment was first ordered on 08/15/25.Review of medication administration records (MAR) revealed Verzenio was documented as being administered to Resident #53 the first time on 08/15/25 at 11:00 A.M.During an interview on 03/10/26 at 8:00 A.M. with the Assistant Director of Nursing (ADON) #210 stated Verzenio had to be acquired from an outside pharmacy, and they didn't get a prescription from oncology. ADON #210 confirmed she documented on 07/02/25 that Resident #53 reported that she should be on a new cancer treatment medication. ADON #210 stated the Ombudsman had been at the facility to investigate the concern. During an interview on 03/11/26 at 10:14 A.M. MDS Nurse #201 and ADON #210 confirmed a prescription for Verzenio was dated 06/26/25. MDS Nurse #201 stated that she discovered Resident #53 was not receiving Verzenio on 08/07/25 and informed nursing staff. Both confirmed there were no clarifications or follow-ups with oncology documented after the nurse's note dated 07/02/25. Both confirmed Verzenio was not administered to Resident #53 until 08/15/25.4. Review of the medical record revealed Resident #3 was admitted on [DATE]. Diagnoses included acute and chronic respiratory failure with hypoxia, type two diabetes mellitus with hyperglycemia, and chronic kidney disease stage 3.Review of the Minimum Data Set (MDS) assessment, dated 02/02/26, revealed the resident was cognitively intact and received insulin. Review of the physician orders, dated 02/28/25, revealed an order for Humalog kwikpen subcutaneous solution 100 unit/milliliters (ml) with instructions to inject 18 units subcutaneously one time a day for diabetes if blood sugar is above 140 milligrams per deciliter (mg/dL) give 18 units.Review of the physician orders, dated 10/13/25, revealed an order for Humalog kwikpen subcutaneous solution 100 unit/ml (insulin) with instructions to inject 2 unit subcutaneously at bedtime for resident requests for elevated glucose at night related to type two diabetes mellitus if blood sugar is above 160. Review of the blood sugar values, dated February 2026, revealed the following blood sugar values for Resident #3: 02/02/26 at 4:24 P.M. blood sugar value was 116 mg/dL, 02/03/26 at 9:06 P.M. blood sugar value was 138 mg/dL, 02/08/26 at 11:24 P.M. blood sugar value was 160 mg/dL, and on 02/09/26 at 7:50 P.M. and 10:40 P.M. blood sugar was 153 mg/dL.Review of the Medication Administration Record, dated February 2026, revealed Resident #3 received 18 units of insulin on 02/02/26 at approximately 4:00 P.M. and 2 units of insulin on 02/03/26, 02/08/26, and 02/09/26 at approximately 9:00 P.M. Review of the blood sugar values, dated March 2026, revealed the following blood sugar values for Resident #3: 03/11/26 at 8:11 P.M. blood sugar value was 140 mg/dL.Review of the Medication Administration Record, dated March 2026, revealed Resident #3 received 2 units of insulin on 03/11/26 approximately 9:00 P.M. Interview on 03/09/26 at 11:39 A.M. with Resident #3 revealed concerns related to insulin administration.Interview on 03/16/26 at 8:36 A.M. with Registered Nurse #201 verified insulin was administered to Resident #3 on the identified dates outside the parameters. Review of the facility policy titled, Pharmacy Services Policy, dated 06/21/17, revealed a pharmaceutical service is available to provide residents with prescription and non-prescription medications, infusion therapy products and related equipment, supplies and services.This deficiency represents non-compliance investigated under Complaint Number 2621295, 2615090 and 2568764.

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Liberty Retirement Community of Lima Inc	2440 Baton Rouge Avenue Lima, OH 45805

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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to notify the physician of an abnormal laboratory (lab) results timely. This affected one (#51) resident of one residents reviewed for laboratory test. The facility census was 47.Findings include:Review of the medical record for Resident #51 revealed an admission date of 05/14/24 with diagnoses including diabetes mellitus, Down's Syndrome, Hirschsprung's disease, and morbid obesity. Resident #51 discharged to the hospital on [DATE] and did not return to the facility. Review of an annual Minimum Data Set (MDS) assessment, dated 05/18/25,indicated Resident #51 had severe cognitive impairment and was dependent upon staff for activities of daily living. The MDS indicated Resident #51 had an indwelling catheter. Review of the medical record for Resident #51 revealed a physician order dated 06/11/25 for urinalysis (UA). Review of the medical record revealed a UA culture was completed on 06/14/25 and indicated the culture was positive for Methicillin Resistant Staphylococcal Aureus (MRSA). Review of the medical record revealed no documentation to support the physician was notified of the abnormal lab results until 06/27/25 and an order was given for Macrobid 100 milligram (mg) one capsule by mouth two times per day for seven days for a Urinary Tract Infection (UTI). Interview on 03/16/26 at 10:34 A.M, with the Assistant Director of Nursing (ADON) #210 confirmed the medical record for Resident #51 did not have documentation support the facility notified the physician timely of the abnormal lab results on 06/14/25.Review of the facility policy titled, Lab and Diagnostic Test Results, dated November 2018, stated the physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. The policy stated when test results are reported to the facility, a nurse would first review the results and identify the urgency of communicating with the attending Physician based on the seriousness of any abnormality, and the individual's current condition. The policy stated the physician could be notified by phone, fax, voicemail, e-mail, mail, pager, or a telephone message to another person acting as the physician's agent (office staff).This deficiency represents non-compliance investigated under Complaint Number 2615090.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews, observations, resident interview, staff interview, review of Tuberculosis (TB) Risk Assessment, and review of policy, the facility failed to properly handle soiled linen for Resident #3. In addition, the facility failed follow enhanced barrier precautions for Residents #39 and #40. The facility failed to complete the TB risk assessment annually. This had the potential to affect all 47 residents. The facility census was 47.Findings include:1. Review of the medical record revealed Resident #3 was admitted on [DATE]. Diagnoses included acute and chronic respiratory failure with hypoxia, type two diabetes mellitus with hyperglycemia, and chronic kidney disease stage 3. Review of the Minimum Data Set (MDS), dated [DATE], revealed the resident was cognitively intact and required set-up/clean up assistance with toileting, showering, and personal hygiene. Review of the care plan, revised on 10/01/25, revealed Resident #3 has mixed bladder incontinence. Interview on 03/11/26 at 12:19 P.M. with Resident #3 revealed the odor is coming from the pile of soiled laundry in the corner of the resident room. Resident #3 stated every day she places soiled laundry on the floor in the corner for the aides to get. Resident #3 stated today housekeeping staff also picked up soiled laundry on the floor and added to the piled in the corner. Interview on 03/11/26 at 12:28 P.M. with Certified Nursing Assistant (CNA) #256 stated she did not know the soiled linen was on the floor and would collect it. After the laundry was collected, a follow-up interview at 12:55 P.M. with CNA #256 verified the laundry was saturated. Interview on 03/12/26 at 11:57 A.M, with Housekeeping #239 verified collected Resident #3's wet soiled laundry on 03/11/26 and placing it directly on the floor in the corner of the room for the aide to gather. 2. Review of the medical record for Resident #40 revealed an admission date of 09/29/2020 with medical diagnoses of cerebral palsy, profound intellectual disabilities, seizures, hypertension, and dysphagia. Review of an annual Minimum Data Set (MDS) assessment, dated 02/11/26, indicated Resident #40 had severe cognitive impairment and was dependent upon staff for all activities of daily living. Review of the physician orders for Resident #40 revealed an order dated 12/11/25 for Enhanced Barrier Precautions (EBP) and an order dated 12/11/25 Isosource 1.5 milliliter (ml) to administer 300 ml bolus five times per day. Observation on 03/16/26 at 1:18 P.M. revealed Certified Nursing Aide (CNA) #245 prepared Resident #40 for incontinence care by explaining the procedure, washing her hands, and applying gloves. The observation revealed an EBP sign posted on Resident #40's door and personal protective equipment (PPE), including gown, gloves, and googles, located in the room. CNA #245 proceeded to complete incontinence care for Resident #40. Observation on 03/16/26 at 1:34 P.M. revealed Licensed Practical Nurse (LPN) #202 observed to use hand sanitizer and apply gloves and then proceeded to administer the tube feeding and water flushes as ordered to Resident #40. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 03/16/26 at 1:41 P.M. with CNA #245 and LPN #202 confirmed Resident #40 was on EBP, there was a sign posted on her bedroom door, and PPE was available in her room. CNA #245 and LPN #202 both confirmed they did not donn a gown when they provided incontinence care or administered the tube feedings. 3. Review of Resident #39's medical record revealed an admission date of 09/06/22. Diagnoses listed included hemiplegia, type two diabetes mellitus, bladder dysfunction, and hypertension. Review of a quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #39 was cognitively intact, had an indwelling urinary catheter, and had received an antibiotic. Review of physician orders revealed an order dated 05/24/25 for EBP for extended-spectrum beta-lactamases (ESBL) and indwelling catheter. Follow EBP protocols when providing care. Observation of Certified Nurse Aide (CNA) #230 and CNA #282 providing care to Resident #39 on 03/12/26 revealed they did not follow EBP protocols. CNA #230 and CNA #282 entered Resident #39 on 03/12/26 at 7:28 A.M. and donned gloves but did not don any gowns. CNA #230 and CNA #282 then assisted Resident #39 with dressing and transfer to a wheelchair using a sit to stand lift (hydraulic lift device). CNA #282 moved Resident #39's urinary catheter collection bag from bedside, hung it on her pants leg pocket, attached it to the lift, then attached it to a wheelchair after transfer. CNA #282 then handed a washcloth to Resident #39 to have him wash his face. During an interview on 03/12/26 at 7:37 A.M. CNA #230 confirmed Resident #39 was on EBP and gowns should be used during care. CNA #230 confirmed a sign alerting staff of EBP and personal protective equipment (PPE) were on Resident #39's entrance door. During an interview on 03/12/26 at 7:39 A.M. CNA #282 confirmed Resident #39 was on EBP and gowns should be used during care. CNA #230 confirmed a sign alerting staff of EBP and PPE were on Resident #39's entrance door. Interview with Infection Preventionist (IP) #246 on 03/12/26 at 7:55 A.M. confirmed Resident #39's was ordered to be in EBP and CNA #230 and CNA #282 should have donned gowns when providing care. Review of the facility's policy titled Enhanced Barrier Precautions dated revised 09/08/25 revealed EBP is indicated for residents with the following conditions when contact precautions (contact, droplet, airborne, etc.) would not otherwise apply. Wounds, this generally includes residents with chronic wounds, and not those with only shorter-lasting wounds, such as skin breaks or skin tears covered with a Band-aid or similar dressing. Indwelling medical devices such as catheters, drains, etc., all intravenous (IV) access points regardless of use (except for peripheral intravenous lines, gastronomy tube (G-tube) or jejunostomy tube (J-tube), tracheostomies or ventilators, and infection or colonization with a multidrug resistant organism (MDRO). PPE includes the use of gloves and gown for high contact care activities. High contact care activities include dressing, bathing/shower/hygiene, transferring in the patient's room, changing linens, toileting/changing briefs, indwelling device care, wound care, and therapy sessions. Use face/eye protection if splash/spray possible. 4. Review of the facility Tuberculosis (TB) Risk Assessment revealed it was completed on 03/12/26. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility did not have documentation to of TB Risk Assessment completed in 2025. Interview on 03/12/26 at 8:13 A.M. with Infection Preventionist (IP) #246 confirmed the facility did not have documentation to support a TB Risk assessment had been completed in 2025. Review of the facility policy titled, Tuberculosis Risk Assessment, revised October 2010 stated the purpose of the TB risk assessment is to help evaluate the risk of transmission of TB within the facility, and to help establish appropriate administrative, environmental and respiratory protection controls for the recognition and/or prevention of TB transmission. The policy stated the TB risk assessment shall be conducted annually to determine appropriate administrative, environmental, and respiratory protection controls needed for the facility based on the current TB risk classification. This deficiency represents non-compliance under Complaint Numbers 2568764, 2615090, and 2698450.