STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365972	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canfield Healthcare Center	2958 Canfield Rd Youngstown, OH 44511

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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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure Resident #83's guardian was permitted to consent or decline influenza and COVID immunizations. This affected one (Resident #83) of three residents reviewed for guardian's consent to treatment. The facility census was 72. Findings include:Review of the closed medical record revealed Resident #83 was admitted [DATE] with diagnoses of ataxic cerebral palsy, epilepsy, nutritional anemia, schizophrenia, and obsessive-compulsive disorder. Review of the emergency contacts revealed co-guardians were listed as the primary contacts. Review of the Amended Letters of Co-Guardianship filed with Mahoning County Probate Court on 12/09/15 revealed Resident #83's father and Resident #83's son were appointed co-guardians of person only and not estate for an indefinite time period or until revoked. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #83 was cognitively intact as evidenced by a score of 15 out of 15 on the Brief Interview for Mental Status (BIMS). Resident #83 required moderate assistance for toileting hygiene, set up/clean up assistance for eating, and supervision for all other activities of daily living (ADL). Review of Resident #83's current care plan revealed the term guardian was absent from the care plan; however, the term resident representative was used throughout. Review of the undated COVID-19 Vaccination Declination Resident Form revealed it was signed by Resident #83 and not signed by a co-guardian. Review of the Influenza Vaccine Consent form dated 2/24 revealed it was signed by Resident #83 and not signed by a co-guardian. Interview on 09/08/25 at 3:25 P.M. with the Director of Nursing (DON) confirmed she was unsure of the consent process, so she had Resident #83 sign the consent and/or declinations. The DON reported she contacted the guardian by phone first although it was not documented in the record.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 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 medical record review, interview and facility policy review, the facility failed to notify Resident #83's guardian of a change in condition requiring hospitalization. The facility also failed to notify Resident #13's guardian of his intent to sign out on leave of absence (LOA) to get her input and failed to inform her of Resident #13's return to the facility involving police escort in a timely manner. This affected two (Residents #13 and #83) of 22 residents reviewed for notification. The facility census was 72. Findings include:1. Review of Resident #13's medical record revealed an admission date of 05/23/25. Resident #13 had a letter of guardianship for person only for an indefinite time dated 04/30/25. Resident #13 had diagnoses including delusional disorders, anti-social personality disorder, anxiety disorder, apraxia (a neurological condition characterized by loss of the ability to perform activities that a person is physically able and willing to do), difficulty walking, and insomnia. Resident #13 had no physician orders regarding LOA. A nursing note by Registered Nurse (RN) #847 dated 05/24/25 at 12:19 A.M. indicated Resident #13 arrived at the facility at 8:16 P.M., transported from the hospital. Resident #13 ambulated into the facility independently while carrying his personal belongings. Upon arrival, Resident #13 immediately expressed his intention to sign out and return home. Resident #13 was provided with education regarding his care plan and the importance of staying at the facility, but he remained insistent on leaving. Unit Manager #844 was made aware of the situation and advised that Resident #13 be re-educated, especially since he reportedly had no alternative place to go. Unit Manager #844 also sent the contact information of Resident #13's legal guardian to notify her of the situation. Resident #13's guardian was contacted, informed of Resident #13's desire to leave and advised that Resident #13 should remain at the facility as he has no safe discharge destination. Resident #13's guardian instructed staff to calm him and, if necessary, use the pink slip (involuntary psychiatric hold) process should he become aggressive. Resident #13 was encouraged to stay and agreed to watch television (TV) for a few minutes before making a final decision. Resident #13 was escorted to the TV lounge and made comfortable. After spending some time there, Resident #13 approached staff and requested to be taken to his room, stating he would remain at the facility for the night and reconsider leaving the following day. A nursing admission assessment dated [DATE] indicated Resident #13 was admitted with a cognitive disorder. Resident #13 was alert and oriented to person, place and time. It was unknown if Resident #13 had a history of exit seeking or wandering. The elopement part of the assessment indicated Resident #13 did not have a history of wandering and/or a pattern tied to Resident #13's past. Resident #13 was not accepting the new admission situation, and Resident #13 had expressed anxiety/apprehension to leave the facility. Resident #13 was determined to be at risk for elopement or unsafe wandering. A baseline care plan dated 05/24/25 indicated Resident #13 was at risk for elopement. Interventions included assessing for hunger, thirst, ambulation, and toileting needs. Wandering evaluations were to be completed upon admission/re-admission, quarterly and as necessary. Resident #13 was to be evaluated for need of a secure unit and the medical provider notified as needed. Interventions included providing diversionary activities as needed and redirecting Resident #13 when appropriate. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note by Licensed Practical Nurse (LPN) #861 dated 05/24/25 at 7:11 P.M. indicated Resident #13 signed out LOA around 3:45 P.M. stating he was going to the store. Resident #13 had not returned at that time. The note included all parties were aware. Review of a LOA sign out sheet dated 05/24/25 revealed Resident #13 signed out at 4:09 (did not indicate if A.M. or P.M. or include an anticipated return time) to go downtown. Sign in was at 8:24 or 8:29 (last number not completely legible) the same day. A nursing note by RN #846 dated 05/24/25 at 10:46 P.M. indicated Resident #13 was returned to the facility with police escorts at 8:10 P.M. No complaints were made. A nursing note dated 05/25/25 at 10:50 P.M. indicated the nurse called the guardian to make her aware Resident #13 had signed out, left and had returned. The nurse left a voice mail requesting the guardian to call back. There was no further documentation of discussions with Resident #13's guardian. A Nurse Practitioner (NP) note by NP #889 dated 07/31/25 indicated Resident #13 was hospitalized on [DATE] due to psychotic and cognitive disorders. Resident #13 was involuntarily probated by his sister for delusions involving Satan stealing his cigarettes and believing his sister was possessed by demons. Resident #13 exhibited poor hygiene, flight of ideas, paranoia and delusions. On 08/27/25 at 8:15 A.M., the Director of Nursing (DON) was interviewed regarding Resident #13 being permitted to leave the facility LOA on 05/24/25 when the guardian had indicated she did not wish for him to leave the facility on 05/23/25. The DON verified because Resident #13 was assessed as cognitively intact and the guardian had stated she did not want him to leave to go home but gave no other parameters for LOA the facility did not believe it was necessary to contact the guardian for feedback. During an interview on 08/27/25 at 11:27 A.M., Resident #13's guardian stated Resident #13 had a long psychiatric stay prior to his admission to the facility. She stated when she was contacted by the facility the night Resident #13 was admitted , she did tell the facility Resident #13 was homeless and had nowhere to go, and if he was unstable the facility should send him back to the psychiatric hospital. Resident #13's guardian stated she presumed staff would know with his history and wanting to leave the facility, he should not be allowed to sign out LOA unless he was accompanied by family or someone from the facility. The guardian stated had staff consulted with her, Resident #13's guardian would have told them there were to be restrictions on Resident #13 signing himself out LOA. Resident #13's guardian stated she believed it was poor judgement on the facility's part if they let him sign himself out LOA. Resident #13's guardian stated she was not notified of Resident #13 leaving LOA and subsequently returning with police intervention. During an interview on 08/28/25 at 8:18 A.M., LPN #861 stated the parties referred to in her progress note on 05/24/25 at 7:11 P.M. was the on-call unit manager (later identified as Unit Manager #844). LPN #861 verified the guardian was not notified when she identified Resident #13 had not returned. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility undated Resident Leave of Absence policy revealed a resident who was cognitively intact with independent decision making with a physician's order may sign themselves out for LOA. The procedure indicated a physician's order was to be obtained for the resident to leave the facility with or without supervision. The physician was to be alerted if the resident was at risk for elopement. Provide the resident or family/responsible party with the facility phone number as needed and instructions to contact the facility if return was delayed more than one hour from the anticipated return time. Contact the resident or family/responsible party if they had not returned within one hour of the anticipated return time. Notify the Executive Director if unable to contact the resident or responsible party, or if they refuse to return. 2. Record review revealed Resident #83 was admitted on [DATE] with diagnoses of ataxic cerebral palsy, epilepsy, nutritional anemia, schizophrenia, and obsessive-compulsive disorder. Review of the Amended Letters of Co-Guardianship filed with Mahoning County Probate Court 12/09/15 revealed Resident #83's father and son were appointed co-guardians of person only for an indefinite time period or until revoked. Review of the obituary for Resident #83 father revealed he passed away 11/27/22 thus making the son the sole guardian of person. The record was not updated to reflect Resident #83's son was the guardian and the primary contact. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #83 was cognitively intact as evidenced by a score of 15 out of 15 on the Brief Interview for Mental Status (BIMS). Resident #83 required moderate assistance for toileting hygiene, set up/clean up assistance for eating, and supervision for all other activities of daily living (ADL). Review of progress note dated 06/19/25 at 9:08 A.M. revealed LPN #856 reported Resident #83 “looked out of it” when she went to her room. LPN #856 called Resident #83's name with no response then proceeded to do a sternal rub, still with no verbal stimuli; however, her eyes were open and blinking. Vital signs were taken. Resident #83 was assessed by the NP, and both the physician and NP ordered she be sent to the hospital for evaluation. Resident #83's family was contacted by the NP with no response. There was no other progress note entries made after 06/19/25 at 9:08 A.M. Interview on 09/04/25 at 1:20 P.M. with LPN #856 confirmed she was the nurse that sent Resident #83 to the hospital and the author of the 06/19/25 progress note. LPN #856 reported she attempted to contact Resident #83's son but was unsuccessful, so she then called the phone number listed for Resident #83's father which was not a valid number. No voice message was left for Resident #83's son who was the legal living guardian. LPN #856 then reported the NP “took over and called the son herself and left a voice message”. LPN #856 further reported that the father's number was called first for changes in condition, but the son was contacted when the father's number was disconnected. Interview on 09/11/25 at 3:53 P.M. with NP #902 revealed that on 06/19/25 she attempted to contact Resident #83's father, but no one answered. She was unable to recall if she left a voice message but stated she did not like to leave messages that may cause panic which was a habit of hers. NP #902 did advise the staff to continue to attempt to contact the family. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the undated Notification of Change Policy revealed the center must inform the resident, consult with the resident's medical practitioner and/or notify the residents' representative, authorized family member or legal power of attorney/guardian when there is a change requiring such notification. Circumstances requiring notification included a transfer or discharge of the resident from the center. This deficiency represents noncompliance investigated under Master Complaint Number 1366502 (OH00167399) and Complaint Numbers 1366501 (OH00167396) and 1366500 (OH00167393).

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, observation and facility policy review, the facility failed to ensure Resident #25 were free from staff-to-resident verbal abuse. This affected one (Resident #25) or two residents reviewed for abuse. The facility census was 72. Findings include:Review of the medical record revealed Resident #25 was admitted on [DATE] with diagnoses including schizoaffective disorder, major depressive disorder (MDD), anxiety, hypertension, and the need for assistance with personal care. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #25 had impaired cognition. She required set up assistance with eating, substantial assistance with oral hygiene, toileting hygiene, dressing, personal hygiene and bed mobility. Resident #25 was dependent on staff for showers. Review of the care plan dated 07/31/25 revealed Resident #25 had impaired cognition related to intellectual disability and cognitive communication deficit. Interventions included staff were to administer all medications, keep routine as consistent as possible in order to decrease confusion, and staff to provide visible clocks, a calendar, low-glare, consistent care routines, familiar objects, and reduced sensory noise as much as possible. Observation on 08/28/25 at 9:45 A.M. revealed Certified Nursing Assistant (CNA) #816 was verbally abusive to Resident #25 when she yelled loudly and aggressively at Resident #25 and stated, Stop crying, or I will shut your door. There were no other residents in the room or hallway. Resident #25 was crying but could barely be heard. Review of the progress notes dated 08/28/25 revealed there were no progress notes related to the incident of witnessed verbal abuse that occurred on 08/25/25. Interview on 08/28/25 at 9:46 A.M. with CNA #816 revealed when the Surveyor asked why she was speaking to the resident in that tone and manner, CNA #816 stated because she needs to shut up and stop crying, she was upsetting other residents, and it needs to stop. On 08/28/25 at 9:47 A.M. incident of verbal abuse was reported to the Administrator and the Regional Director of Clinical Operations (RDCO) #869. While walking up the hall to the Administrators office, CNA #816 came down the hall and very closely approached the surveyor and asked where the [expletive] are you going then went back down to the nurses' station and waited there. On 08/28/25 at 9:49 A.M. the Administrator and RDCO #869 interviewed CNA #816, ensured Resident #25 was safe and escorted CNA #816 out of the building and began their investigation. Interview on 09/08/25 at 2:00 P.M. with Resident #25 revealed she was scared when CNA #816 yelled at her and told her she was going to shut the door. Observation on 09/04/25 at 9:58 A.M. of Resident #25 revealed she was sitting on the side of their bed crying with staff present trying to console the resident. Observation made on 09/08/25 at 1:54 P.M. of Resident #25 revealed they were resident quietly in their room with no distress noted. Review of the undated facility policy titled Ohio Abuse, Neglect, and Misappropriation revealed it was the intent of this facility to prevent the abuse, mistreatment, or neglect of residents or the misappropriation of tier property, corporal punishment and/or involuntary seclusion and to provide guidance to direct staff to manage any concerns or allegations of abuse, neglect or misappropriation of their property. Furthermore, it is the intent of this facility to employ only properly screened persons as a part of the resident care team by the applicable requirements. This deficiency represents noncompliance investigated under Complaint Number 1366499 (OH00167390).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and policy review, the facility failed to ensure care conferences were completed quarterly for Residents #4, #25, #43, and #83. This affected four (Residents #4, #25, #43, and #83) of the eight residents reviewed for care conferences. The facility census was 72. Findings include:1. Record review revealed Resident #4 was admitted on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, aphasia, dysphagia, chronic obstructive pulmonary disease, and adjustment disorder with mixed anxiety and depression. Review of Resident #4's progress notes revealed Resident #4's last care conference was 10/05/23. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #4 was moderately cognitively impaired as evidenced by a score of eight out of 15 on the Brief Interview for Mental Status (BIMS). Resident #4 was dependent on staff for all activities of daily living (ADL). Review of Resident #4's care plan revealed it was routinely revised or updated with the most recent revision occurring on 08/07/25. Interview on 08/03/25 at 4:53 P.M. with Social Service Designee (SSD) #850 revealed the last care conference for Resident #4 was 02/07/25, but she was unable to provide documented evidence to support a care conference was held. 2. Record review revealed Resident #83 was admitted on [DATE] with diagnoses of ataxic cerebral palsy, epilepsy, nutritional anemia, schizophrenia, and obsessive-compulsive disorder. Review of Resident #83's progress notes revealed a care conference was conducted 02/10/25. The last care conference prior to that was 10/17/23. Review of Resident #83's care plan revealed it was routinely revised or updated with the most recent revision occurring 02/26/25. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #83 was cognitively intact as evidenced by a BIMS score of 15 out of 15. Resident #83 required moderate assistance for toileting hygiene, set up/clean up assistance for eating, and supervision for all other ADL. Interview on 08/03/25 at 4:53 P.M. with SSD #850 confirmed the last care conference for Resident #83 was 10/17/23. 3. Record review revealed Resident #25 was admitted on [DATE] with diagnoses of schizoaffective disorder, major depressive disorder, obesity, chronic kidney disease, and type II diabetes. Review of Resident #25's progress notes revealed a care conference was conducted 02/10/25. The last care conference prior to that was 11/14/23. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #25 was moderately cognitively impaired as evidenced by a BIMS score of eight out of 15. Resident #25 required maximal assistance with oral hygiene, toileting hygiene, personal hygiene, and transfers. Review of Resident #25's care plan revealed it was routinely revised or updated with the most recent revision occurring 06/30/25. Interview on 08/03/25 at 4:53 P.M. with Social Service Designee #850 confirmed no other care conferences were completed after 11/14/23 for Resident #25. 4. Record review revealed Resident #43 was admitted on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, encephalopathy, occlusion and stenosis of the right carotid artery, and aphasia. Review of Resident #43's progress notes revealed the last care conference occurred 11/03/23. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #43 was severely cognitively impaired as evidenced by a BIMS score of four out of 15. Resident #43 was dependent on staff for toileting, dressing, and shower transfers and moderate assistance for personal hygiene, and toilet and chair transfers. Review of Resident #43's care plan revealed it was routinely revised or updated with the most recent revision occurring 08/19/25. Interview on 08/03/25 at 4:53 P.M. with SSD #850 revealed the last care conference for Resident #43 was 02/07/25, but she was unable to provide documented evidence to support a care conference was held. Review of the undated Plan of Care Overview Policy revealed the facility would review care plans quarterly and/or with significant changes in care. Attendees would sign and date the care plan meeting agendas/documents. This deficiency represents noncompliance investigated under Complaint Number 1366500 (OH00167393).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, review of the shower audit tool and facility policy review, the facility failed to ensure Resident #6 received showers as scheduled. This affected one (Resident #6) of one resident reviewed for activities of daily living (ADL). The facility census was 72. Findings include:Record review revealed Resident #6 was admitted on [DATE] with diagnoses of immobility syndrome, severe protein-calorie malnutrition, and extended spectrum beta lactamase (ESBL) resistance. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #6 was dependent on staff for toileting hygiene, showers, dressing, and transfers. Resident #6 was cognitively intact. Review of Resident #6's current care plan revealed Resident #6 had an ADL self-care performance deficit and required the staff to do all of the effort or have two or more staff to assist. Interview on 08/25/25 at 11:08 A.M. with Resident #6 revealed she was not bathed regularly and at times went one to two weeks without a shower or bed bath. Review of Resident #6's progress notes from June to September 2025 revealed on Thursday 08/28/25 it was noted Resident #6 refused a shower but requested a bed bath be given the following day. There was no documented evidence Resident #6 ever received a shower/bed bath on 08/29/25 as requested. The progress note dated 09/03/25 at 6:28 A.M. revealed Resident #6 received a bed bath. Interview on 09/08/25 at 10:49 A.M. with Certified Nursing Assistant (CNA) #829 revealed specific room numbers were assigned for showers each day; however, there were issues getting showers completed either because there was not enough staff or some staff unwilling to shower residents. Interview on 09/08/25 at 8:42 A.M. with Resident #6 revealed a shower was received the evening of 09/07/25 by CNA #845 which was not the assigned shower day. The shower was received on Sunday when her scheduled shower days were Wednesdays and Fridays. Interview on 09/08/25 at 10:21 A.M. with the Director of Nursing (DON) who was unable to dispute Resident #6 did not receive showers as scheduled and denied there were any staffing issues that affected residents getting showered. Interview on 09/08/25 at 10:49 A.M. with CNA #845 confirmed Resident #6 requested a shower. CNA #845 provided Resident #6 a shower because time allowed. CNA #845 denied any staffing concerns and was unable to provide an explanation as to why Resident #6 was not showered on Wednesdays and Fridays, which were the scheduled days. Review of the Shower Audit Form updated 08/25/25 confirmed Resident #6's scheduled shower days were Wednesdays and Fridays on the night shift which was from 7:00 P.M. to 7:00 A.M. Review of the Shower Sheet and Body/Skin Infection Form for Nurse Aides revealed a bed bath/shower was completed for Resident #6 on 06/09/25, 06/15/25, 06/27/25, 07/02/25, 07/25/25 (refused), 08/27/25 (refused) and 09/02/25. No other documentation was provided to show additional showers or bed baths were given. Review of the undated Routine Resident Care Policy stated routine daily care was provided by a CNA under the supervision of a nurse. Routine care included but was not limited to bathing, dressing, eating/hydration, and toileting. Review of the undated Perineal Care Policy stated perineal care would be planned for each individual resident to meet his/her specific needs, choice, and frequency.

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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. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, and facility policy review, the facility failed to ensure residents were provided with one-on-one activities to meet their interests and needs. This affected three (Residents #25, #29, and #83) of three residents reviewed for activities. The facility census was 72. Findings include:1. Review of Resident #25's medical record revealed an admission date of 06/09/25 with diagnoses included schizoaffective disorder, major depressive disorder (MDD), anxiety, hypertension, and need for assistance with personal care. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #25 had impaired cognition and required setup assistance with eating, substantial assistance for oral hygiene, toileting, dressing, personal hygiene, and bed mobility, and finally Resident #25 was dependent on staff for showers. Review of the care plan dated 07/31/25 revealed Resident #25 was alert and oriented and could make her needs known. She continued to sleep a lot throughout the day, enjoyed Bingo when she was able to attend; however, for right now, she just wanted room visits. Staff would encourage her to participate in activities. Activity staff would continue room visits, and ensure her needs were met. Goals and interventions included Resident #25 was encouraged to participate when she was up and out of bed, staff would also do one-on-one visits. Staff were to encourage the resident to attend activities to support participation. Staff were to invite the resident to scheduled activities and provide one-on-one visits if unable to attend out-of-room events. Review of Resident #25's one-on-one master list for August 2025 revealed she was to receive a one-on-one activity twice a week on Wednesday and Saturday. Review of Resident #25's Record of One-on-One Activities for August 2025 revealed there was only one entry for the month stating the resident denied the activity. There were initials present by staff, but no one could read them. Interview on 09/08/25 at 10:32 A.M. with Resident #25 revealed she was not offered the opportunity to go out of her room to go to activities, and she would like to. She stated staff were mean to her and kept her in her room. Resident #25 stated staff from activities only came into her room when they wanted to, and they did not do anything with her when they came in. Interview on 09/09/25 at 12:12 P.M. with Activity Director (AD) #800 revealed documentation and one-on-one room visits were a problem. Surveyor asked for one month of documentation and a list of all one-on-one residents, and AD #800 stated she would not be able to find one month of documentation for one-on-one visits because she knew it did not exist. Observations made on 09/10/25 of Resident #25 at multiple times throughout the day revealed there were no one-on-one activities observed being completed during these observations. Interview on 09/12/25 at 12:00 P.M. with Activity Assistant (AA) #803 revealed some one-on-one activities were completed for Resident #25, but none of them were documented. AA #803 stated there was only one, one-on-one activity documented for August 2025. No other documentation was provided. 2. Review of Resident #29's medical record revealed an admission date of 08/01/24 with diagnoses including chronic respiratory failure with hypercapnia, obstructive sleep apnea, morbid obesity, chronic kidney disease (CKD) stage II, spinal stenosis, osteoarthritis, and MDD. Review of the annual MDS 3.0 assessment dated [DATE] revealed Resident #29 had intact cognition, was dependent on staff for toileting hygiene, showers, dressing, transfer including sit to lying, lying to sitting and required moderate assistance by staff for rolling left to right. Resident #29 used a wheelchair for mobility. Review of the care plan dated 02/19/25 revealed Resident #29 had little or no activity involvement related to little interest or pleasure in doing things outside of his room. Resident #29 would carry on a conversation with the activity's assistants about his gaming on his iPad and his streaming services and didn't mind the one-on-one visits. Goals and interventions included Resident #29 would participate in activities of choice through the review date, Resident #29 would show engagement in activities of interest, Resident #29 would accept and participate in one-on-one visits. Staff would assist with transport to activities as needed, encourage attendance to entertainment programs, large and small group activities, volunteer demonstrations, and religious activities. Staff would interview and determine resident activity preferences, they would introduce the resident to others with similar interests, invite the resident to scheduled activities, and provide one-on-one in-room visits if unable to attend out-of-room events. Review of facility one-on-one master list dated August 2025 revealed Resident #29 was to have one-on-one visits with activities twice a week on Sundays and Thursdays. Review of Resident #29's Record of One-on-One Activities form dated for 08/21/25 stated the resident just wanted to vent and chat, and on 08/24/25 staff sat and spoke with the resident about movies and gave the resident a daily chronicle to read. On 08/31/25 staff just sat and chatted

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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 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 review and interviews, the facility failed to ensure Resident #83's emergency contact was notified of a change in condition. This affected one (Resident #83) out of three residents reviewed for notification of change in condition. The facility census was 72. Findings include:Review of Resident #83's closed medical record revealed an admission date of 01/07/18 and a discharge date of 06/26/25. Diagnoses included ataxic cerebral palsy, epilepsy, anemia, thoracic aortic aneurysm, schizophrenia, obsessive compulsive disorder, major depressive disorder (MDD), and need for assistance with Activities of Daily Living (ADL) and personal care. Review of Resident #83's emergency contacts revealed the resident's father was listed as emergency contact #1; however, throughout the investigation it was identified the resident's father passed away in November of 2022. Resident #83's brother was listed as emergency contact #2. Review of the discharge MDS 3.0 assessment dated [DATE] revealed Resident #83 had slight impairment of cognition, she required supervision with eating, and oral hygiene and substantial assistance for toileting hygiene, showers, dressing, and personal hygiene. Review of Resident #83's progress notes from 04/28/25 to 06/26/25 revealed on 04/28/25 there was a urinalysis with culture and sensitivity (UA C&S) ordered with no supporting documentation as to why or who ordered it and if Resident #83's family was notified. Further review of Resident #83's progress notes revealed there were late entry progress notes entered on 06/04/25 at 2:29 P.M. effective for 05/05/25 at 2:09 P.M. and another late entry note dated 06/09/25 at 2:09 P.M. effective for 05/06/25 at 2:09 P.M. There was no evidence in the progress notes the resident's emergency contact was notified. Additionally, on 06/19/25 at 9:08 A.M. it was documented by Registered Nurse (RN) #844 that she went into Resident #83's room to find the resident looked out of it, she called the resident's name with no response, did a sternal rub on the resident with no response; the resident's eyes were open and blinking, but she was not responsive. Vital signs were assessed: blood pressure 98/71, heart rate 97, temperature 97.5 degrees Fahrenheit (F) and oxygen saturation was 97 percent on room air. RN #844 spoke with the physician who gave an order to send the resident to the hospital. Resident #83 was also evaluated by the Nurse Practitioner (NP) who also ordered the resident to go to the hospital. The progress note stated the resident's family was contracted by the NP with no response. Interview on 08/27/25 at 12:45 P.M. with the Director of Nursing (DON) confirmed the late entry documentation for Resident #83 for antibiotic use was completed one month later. The DON had no explanation why documentation was not completed timely. The DON confirmed Resident #83's father who was listed as emergency contact #1 had passed away in 2022, and the chart was not updated; therefore, no one in the resident's family was notified of her change in condition. Interview on 09/08/25 at 4:22 P.M. with RN #844 revealed Resident #83 was experiencing altered mental status. She was more depressed due to a roommate change. She thought it was a behavior and ordered the UA C&S. RN #844 confirmed she did not document the behaviors the resident was having, and she did not document if she notified the NP or the Physician. RN #844 confirmed she did not notify the family of the new order for the UA C&S, nor did she document any of this information. Review of the undated facility policy titled Notification of Change in Condition revealed it was the policy of the facility to provide resident centered care that meets the psychosocial, physical, and emotional needs, concerns of the residents, The safety of residents, staff, and visitors is of primary importance. The purpose of this policy is to provide guidance for notifications made to residents, resident representatives, and authorized family members for resident changes in condition. Changes may include but are not limited to accidents, incidents, transfers, changes in overall health status, significant medical changes, therapy services changes, transfer, hospitalizations, or death.This deficiency represents noncompliance investigated under Complaint Number 1366500 (OH00167393).

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of a facility self-report incident, facility investigation review, police report review, policy review and interviews, the facility failed to provide adequate supervision and/or intervention to prevent resident elopement. This resulted in Immediate Jeopardy and the potential for actual harm beginning on 05/24/25 when Resident #13, who was assessed as an elopement risk, had exit seeking behaviors and was deemed incompetent by the court system, was permitted by staff to leave the facility unattended and without guardian consent. The resident's whereabouts were unknown until the resident was returned to the facility via police escort on this same date. The Immediate Jeopardy and potential for actual harm continued on 08/16/25 when staff allowed Resident #61, a moderately cognitively impaired resident to leave the facility unattended. The resident's whereabouts were unknown until the resident was found by police, on 08/17/25 a half mile from the facility sleeping on the ground behind a gas station. The resident was transported to the hospital for evaluation. In addition to the two incidents of elopement, the facility failed to have adequate systems in place to identify risks associated with its current practice of determining if residents could safely leave the facility unsupervised/unattended. In addition, concerns that did not rise to Immediate Jeopardy were identified when the facility failed to adequately supervise Resident #11, #37, #40 and #68 related to smoking and possession of smoking materials for safety/accidents. The facility also failed to ensure fall interventions were individualized and comprehensive to prevent falls for Residents #5. This affected two residents (#13 and #61) of three residents reviewed for wandering/elopement, four residents (#11, #37, #40 and #68) of 15 residents reviewed for smoking and one resident (#5) of three residents reviewed for falls. The facility identified three additional residents with guardianship in place (Resident #10, #51 and #55) and 21 additional residents with cognitive impairment (Resident #4, #8, #9, #11, #19, #22, #25, #31, #33, #34, #43, #44, #47, #51, #53, #61, #62, #63, #64, #66 and #72). The facility census was 72. On 08/28/25 at 2:04 P.M. the Administrator, Director of Nursing (DON) and Regional Registered Nurse (RN) #869 were notified Immediate Jeopardy began on 05/24/25 when the facility failed to have effective systems in place to prevent resident elopement (Resident #13 and #61) and to ensure residents' leaving the facility or with a desire to leave the facility were safe to be in the community independently and unsupervised. In addition, the facility failed to ensure adequate systems were in place to timely identify when residents were missing to ensure proper action was immediately taken. No changes in the facility's practice for determining if residents were able to leave the facility unattended was completed by the facility between 05/24/25 and 08/28/25. The Immediate Jeopardy was removed on 08/28/25 when the facility implemented the following corrective actions. On 08/17/25 the Administrator provided all staff education related to the facility elopement policy and procedures. On 08/18/25 Assistant Director of Nursing (ADON) #805 completed wandering assessments for all residents. On 08/18/25 the Administrator conducted a facility elopement drill. On 08/28/25 at 3:40 P.M. ADON #805 spoke with Resident #13's guardian, related to the resident's ability to leave the facility with supervision. On 08/28/25 by 6:00 P.M. the DON, Unit Manager #844 and ADON #805 re-assessed all residents for elopement risk. The results of the assessments revealed Resident #11, #13, #31, and #61 were identified as elopement risk. On 08/28/25 at 10:30 A.M., the door codes were changed by the door company. On 08/28/25 by 6:00 P.M., all residents were reviewed to determine if they were able to go on LOA supervised or unsupervised and orders were written to reflect the findings. On 08/28/25 the DON, ADON #805 and Unit Manager #844 consulted with resident families/guardians and physicians to determine resident LOA status. On 08/28/25 the DON/designee placed a list of residents (#4, #8, #9, #10, #11, #13, #22, #25, #31, #33, #34, #36, #43, #51, #53, #55, #61, and #66) who were not permitted to go on leave of absence (LOA) unsupervised at both nurses' stations and at the front receptionist area. On 08/28/25 Regional RN #869 reviewed and updated the elopement binders on all units. On 08/28/25, all staff were educated by Regional RN #869, LPN #865, Mobile Business Office Manager #890, Administrator, DON, ADON #805, Regional Director of Environmental Services #891, Dietary Manager #876, and Regional Dietary Manager #892 regarding all residents being required to have a physician order for LOA and if the LOA was required to be supervised or could be unsupervised. All staff were educated that nobody was to assist any resident out of the facility for any reason without consulting with the charge nurse who was assigned to that resident. Once a staff member confirmed with the nurse that a resident was permitted to go LOA, the staff member must enter the code without the resident seeing the code. At no time was it

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A nursing note by RN #847 dated 05/24/25 at 12:19 A.M. indicated Resident #13 arrived at the facility at 8:16 P.M., transported from the hospital. Resident #13 ambulated into the facility independently while carrying his personal belongings. Upon arrival, Resident #13 immediately expressed his intention to sign out and return home. Resident #13 was provided with education regarding his care plan and the importance of staying at the facility, but he remained insistent on leaving. Unit Manager #844 was made aware of the situation and advised that Resident #13 be re-educated, especially since he reportedly had no alternative place to go. Unit Manager #844 also sent the contact information of Resident #13's legal guardian to notify her of the situation. Resident #13's guardian was contacted, informed of Resident #13's desire to leave and advised that Resident #13 should remain at the facility as he has no safe discharge destination. Resident #13's guardian instructed staff to calm him and, if necessary, use the pink slip (involuntary psychiatric hold) process should he become aggressive. Resident #13 was encouraged to stay and agreed to watch television (TV) for a few minutes before making a final decision. Resident #13 was escorted to the TV lounge and made comfortable. After spending some time there, Resident #13 approached staff and requested to be taken to his room, stating he would remain at the facility for the night and reconsider leaving the following day. A nursing admission assessment dated [DATE] indicated Resident #13 was admitted with a cognitive disorder. Resident #13 was alert and oriented to person, place and time. It was unknown if Resident #13 had a history of exit seeking or wandering. The elopement part of the assessment indicated Resident #13 did not have a history of wandering and/or a pattern tied to Resident #13's past. Resident #13 was not accepting the new admission situation and Resident #13 had expressed anxiety/apprehension to leave the facility. Resident #13 was determined to be at risk for elopement or unsafe wandering. A baseline care plan indicated Resident #13 was at risk for elopement. Interventions included assessing for hunger, thirst, ambulation, and toileting needs. Wandering evaluations were to be completed upon admission/re-admission, quarterly and as necessary. Resident #13 was to be evaluated for need of a secure unit and the medical provider notified as needed. Interventions included providing diversionary activities as needed and redirecting Resident #13 when appropriate. A telehealth physician note by Physician #888 on 05/24/25 at 3:31 A.M. indicated Resident #13 was admitted after a psychiatric hospitalization. According to discharge papers, it appeared he had new onset delusions. A nursing note by LPN #861 dated 05/24/25 at 7:11 P.M. indicated Resident #13 signed out LOA around 3:45 P.M. stating he was going to the store. Resident #13 had not returned at that time. The note included all parties were aware. Review of a LOA sign out sheet dated 05/24/25 revealed Resident #13 signed out at 4:09 (did not indicate if A.M. or P.M. or include an anticipated return time) to go downtown. Sign in was at 8:24 or 8:29 (last number not completely legible) the same day. A nursing note by RN #846 dated 05/24/25 at 10:46 P.M. indicated Resident #13 was returned to the facility with police escorts at 8:10 P.M. No complaints were made. Record review revealed there was no evidence of further interventions or change in LOA process at this time for Resident #13. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 was able to make himself understood and was able to understand others. A Brief Interview for Mental Status (BIMS) assessment indicated Resident #13 was cognitively intact with a score of 13 (out of 15 possible points). No signs of psychosis were noted. Wandering occurred daily. Wandering placed Resident #13 at significant risk of getting to a potentially dangerous place. Resident #13 was assessed as independent with walking 150 feet, once he was standing, in a corridor or similar space with no mobility devices. A nursing note by RN #805 dated 07/10/25 at 10:57 A.M. indicated Resident #13 began to exit seek. Resident #13 did not have clear directive as to where or why. A wanderguard device (a bracelet that alerts staff if a resident tries to leave a safe area) was applied. A voicemail was left for Resident #13's guardian. The resident's care plan was updated on 07/14/25 related to the wanderguard use and orders. A Nurse Practitioner (NP) note by NP #889 dated 07/31/25 indicated Resident #13 was hospitalized on [DATE] due to psychotic and cognitive disorders. Resident #13 was involuntarily probated by his sister for delusions involving Satan stealing his cigarettes and believing his sister was possessed by demons. Resident #13 exhibited poor hygiene, flight of ideas, paranoia and delusions. Review of the facility undated Resident Leave of Absence policy revealed a resident who was cognitively intact with independent decision making with a physician's order may sign themselves out for LOA. The procedure indicated a physician's order was to be obtained for the resident to leave the facility with or without supervision. The physician was to be alerted if the resident was at risk for elopement. Provide the resident or family/responsible party with the facility phone number as needed and instructions to contact the facility if return was delayed more than one hour from the anticipated return time. Contact the resident or family/responsible party if they had not returned within one hour of the anticipated return time. Notify the Executive Director if unable to contact the resident or responsible party, or if they refuse to return. On 08/27/25 at 8:15 A.M., the DON was interviewed regarding the facility LOA process. The DON indicated if a resident wanted to sign out LOA, nurses or herself checked a resident's BIMS score and expected it to be over 12 for a resident to leave unattended. Each resident had a LOA form in a notebook at their respective nursing station. Upon review of Resident #13's LOA form, the DON verified Resident #13 had not designated a planned return time when leaving in May 2025. The DON was asked about the rationale for Resident #13 being able to sign LOA when he had been assessed as an elopement risk and stated she would have to research it. On 08/27/25 at 10:58 A.M., the DON revealed Resident #13 was able to leave the facility on LOA by stating Resident #13 had been assessed as cognitively intact. The DON stated when the guardian was contacted the night of admission when Resident #13 wanted to leave, she had only indicated Resident #13 could not leave the facility to go home as he had no home or other alternate placement. The DON stated the guardian did not specifically state Resident #13 could not go out on LOA. During an interview on 08/27/25 at 10:13 A.M., LPN #859 stated if a resident wanted to go out LOA, they had to sign out on the LOA paper and nurses were to document it in the computer (recently started alert charting) that was accessible to the nurses and probably management, but she was not sure. The LPN revealed there was a list of residents who could not sign out LOA at the nursing station and front desk. LPN #859 was unable to identify who made the determination Resident #13 was able to be signed out LOA on 05/24/25. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 08/27/25 at 10:28 A.M., Resident #13 stated he continued to want to leave the facility and had spoken to everybody at the facility about wanting to leave. Resident #13 did not wish to speak about his LOA when police escorted him back to the facility. During an interview on 08/27/25 at 11:27 A.M., Resident #13's guardian stated Resident #13 had a long psychiatric stay prior to his admission to the facility. She stated when she was contacted by the facility the night Resident #13 was admitted , she did tell the facility Resident #13 was homeless and had nowhere to go and if he was unstable the facility should send him back to the psychiatric hospital. Resident #13's guardian stated she presumed staff would know with his history and wanting to leave the facility he should not be allowed to sign out LOA unless he was accompanied by family or someone from the facility. The guardian stated had staff consulted with her, Resident #13's guardian would have told them there were to be restrictions on Resident #13 signing himself out LOA. Resident #13's guardian stated she believed it was poor judgement on the facility's part if they let him sign himself out LOA. Resident #13's guardian stated she was not notified of Resident #13 leaving LOA and subsequently returning with police intervention. Resident #13's guardian stated Resident #13 had a son in Florida but was homeless for much of his life. Resident #13 was admitted to the psychiatric hospital after he became psychotic and tried to kill his sister who he was staying with. During an interview on 08/27/25 at 10:14 A.M., Certified Nursing Assistant (CNA) #835 stated nursing assistants could let residents sign out LOA if they were not on a list at the nursing station as not being permitted to go LOA. During an interview on 08/27/25 at 11:45 A.M., Regional RN #869 stated she did not know Resident #13 well enough to know if he should have been permitted to sign out LOA or if he should have been assessed as an elopement risk based on not wanting to be at the facility. RN #869 stated staff did not always have a resident's history when first admitted . Based on that, the facility probably should have waited until they were more familiar with Resident #13 to determine if he could safely leave the facility independently. RN #869 stated Resident #13 was assessed as cognitively intact on admission and was used to being homeless. During an interview on 08/27/25 at 5:10 P.M., the Administrator stated the facility had not notified the police when Resident #13 had not returned from LOA on 05/24/25, stating Resident #13 was known by the police in the community from past interactions. The Administrator revealed police had seen Resident #13 and stopped to inquire about what he was doing at an undisclosed location, and Resident #13 was able to inform them he was a resident of the facility. During an interview on 08/28/25 at 8:10 A.M., RN #846 stated she was unable to recall if the police indicated why they had picked up Resident #13 and returned him to the facility on [DATE]. RN #846 stated if a resident wished to sign out LOA they had to be independent and cognitively clear. Nurses have them sign a form saying when they expect to return and document. If a resident had a guardian, they were permitted to leave with the guardian. However, the RN revealed the facility allowed residents who met the criteria of cognitive abilities and independence to sign out for LOA without guardian input. During an interview on 08/28/25 at 8:18 A.M., LPN #861 stated the parties referred to in her progress note on 05/24/25 at 7:11 P.M. was the on-call unit manager (later identified as Unit Manager #844). LPN #861 stated for a resident to be able to sign out LOA she referred to a list or asked the DON or unit manager. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 08/28/25 at 8:23 A.M., the Administrator stated she had never been informed of Resident #13 leaving the facility on LOA until it was brought to her attention after questioning by the survey team. During an interview on 08/28/25 at 9:56 A.M., Unit Manager #844 stated when residents wanted to go out on LOA it was based largely on the cognitive scores on the BIMS interview. However, the facility tried not to let residents sign out on LOA for the first 24 hours after admission. A resident was permitted to leave the facility LOA if they had a guardian unless the guardian had provided specific instruction for them not to do so. Unit Manager #844 stated she was not aware of Resident #13 signing out LOA on 05/24/25 until staff called to report he had been returned to the facility by police. Unit Manager #844 stated it was her understanding Resident #13 wanted to go to the hospital to get personal items he believed were still there. Unit Manager #844 stated police were familiar with Resident #13 and simply gave him a ride to the facility, stating no police report had been filed. On 08/28/25, the local police department verified there was no police report involving Resident #13 on 05/24/25. During an interview on 08/28/25 at 12:47 P.M., RN #847 stated she assessed Resident #13 as an elopement risk on admission because he was very aggressive regarding his desire to want to leave and go home because there was nobody at his home to take care of it. RN #847 stated Resident #13 hovered at the front entrance for a long time, making attempts to leave but could not because he did not have the code to open the door. RN #847 stated Resident #13 was so upset he could not leave he made threatening moves toward her and only stopped when other residents placed themselves between her and Resident #13. On 08/28/25 at 4:25 P.M., ADON #805 spoke with Resident #13's guardian who indicated Resident #13 was to only go on supervised LOA with the guardian only. If anyone other than the guardian wanted to leave the facility with the resident, the guardian must be notified and give permission. During an interview on 09/02/25 at 11:21 A.M., LPN #858 stated she was not aware Resident #13 was unable to leave the facility on 05/24/25. Police had phoned the facility after her shift started (night shift) and told her Resident #13 was unsupervised downtown, maybe at the bus stop or the hospital, and they knew he should not be wandering around unaccompanied. Police offered to return Resident #13 to the facility. Once he arrived, Resident #13 was upset, and she explained to him he could not leave when he had a guardian. Resident #13 appeared to be confused and stated he did not know he had a guardian. During an interview on 09/02/25 at 4:18 P.M., the Medical Director stated he did review facility policies and provide input. However, regardless of how good a policy was, it was only effective upon staff implementing it. The Medical Director stated he had not been asked to provide input for LOA orders in the past three months. The facility had their own criteria for addressing LOA and would not necessarily involve guardian notification. Per the medical director, Resident #13's going LOA on 05/24/25 was not appropriate as Resident #13 had not been at the facility long enough to be assessed for health risks associated with him going LOA. 2. Record review revealed Resident #61 was admitted [DATE] with diagnoses of unspecified dementia, severe, with behavioral disturbance, unspecified mood disorder, alcohol dependence in remission, and cognitive communication deficit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Wandering Observation Tool dated 06/13/25 and 07/14/25 revealed Resident #61 was not at risk for wandering or eloping. Review of the quarterly MDS assessment dated [DATE] revealed Resident #61 was moderately cognitively impaired based on a score of eight out of 15 on the BIMS scale. The MDS revealed the resident was independent with all activities of daily living. Review of the progress note dated 08/17/25 at 2:57 A.M. by Curricular Practical Training (CPT) Intern RN #846 revealed Resident #61 was last seen (on 08/16/25) between 8:00 P.M. and 8:30 P.M. during medication administration. At regular night rounds, CPT Intern RN #846 noticed Resident #61 was not in his room. A facility and ground search was conducted, and Resident #61 was not found. The Nurse Supervisor LPN #858 was notified at 2:00 A.M. The Nurse Manager #844 contacted Resident #61's mother, the hospital, and various police stations, all of which were unaware of Resident #61's location. Review of the progress note dated 08/17/25 at 9:23 A.M. by Charge Nurse #842 revealed a call was received from the Local Police Department that Resident #61 was being transported to the hospital for an unknown reason. Review of the progress note dated 08/17/25 at 4:01 P.M. by RN Unit Manager #844 revealed Resident #61 was placed on 1:1 supervision upon return to the facility. Review of the physician orders revealed Resident #61 was placed on 1:1 supervision effective 08/17/25. Review of the progress note dated 08/17/25 at 4:04 P.M. by Charge Nurse #842 revealed Resident #61 returned to the facility (on 08/17/25) at 3:45 P.M. by ambulance with two staff and was alert and oriented to self. Resident #61 refused to have a wanderguard placed on his body. Review of a police report from the Local Police Department dated 08/17/25 revealed the facility reported a missing person incident on 08/17/25 at 2:53 A.M. The responding officer arrived at the facility at 4:15 A.M and spoke with healthcare worker CPT Intern RN #846 upon arrival. It was reported that Resident #61 had wandered away from the facility sometime after 8:30 P.M. on 08/16/25. CPT Intern RN #846 advised Resident #61suffered from depression, mood disorders, and alcoholism which caused him confusion at times. CPT Intern RN #846 advised she last gave the resident his medications on 08/16/25 at 8:30 P.M. at which time she watched him take a phone call and walk outside for a cigarette. She further stated that he had wandered from the facility before but not for this length of time. On 08/17/25 time unspecified, Youngstown Police Department received a message from Austintown Police Department stating Resident #61 was located by their officers and was being transported to the local emergency room. The facility was notified, and Resident #61 was removed from Law Enforcement Automated Data System (LEADS). Review of the Wandering Observation Tool dated 08/17/25 revealed Resident #61 was identified as a high risk for elopement or unsafe wandering. Review of the progress note dated 08/17/25 at 5:58 P.M. by LPN #858 revealed vital signs were obtained and a skin assessment was completed. There were no known injuries noted. There were no new orders from the emergency department, and Resident #61 continued to refuse a wanderguard. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the investigation of self-reported incident (SRI) tracking number 264129 revealed the following sequence of events: · On 08/16/25 at 7:30 P.M. Certified Nursing Assistant (CNA) #817 observed Resident #61 in his room and was told “a few hours later” Resident #61 was gone. · On 08/16/25 around 9:30 P.M. CNA #828 reported Resident #61 was seen by the front door attempting to put in door code to go outside and smoke. To not cause the door alarm to go off, CNA #828 entered the code and let Resident #61 out the front door to go smoke. CNA #828 observed Resident #61 walking towards the left side of the facility to sit at the table and chairs. CNA #828 revealed the resident did not have on a wanderguard and therefore, was not an elopement risk prior to letting him outside. · On 08/16/25 at 9:30 P.M. CNA #809 reported seeing Resident #61 at the bus stop when she went to a store across the street on her break, but the resident “was gone” when she came back. Around 2:00 A.M. she noticed he was not in his room and notified the nurse at which time they began to look for him. · On 08/16/25 at an unspecified time LPN #858 was notified by CNA #809 that Resident #61 was not in his room and unable to be found. LPN #858 initiated the facility's elopement action plan, and staff searched inside and outside the facility, but Resident #61was not accounted for. Management was notified during the search. · On 08/17/25 at 2:35 A.M. LPN #858 contacted Resident #61's mom and determined Resident #61was not there. · On 08/17/25 between 2:40 A.M. and 3:35 A.M. the police and hospital were contacted, but Resident #61 was still not located. A voice message was left with Resident #61's friend who was also listed as a contact. LPN #858 made multiple attempts to reach Resident #61 on his cell phone but was unsuccessful. As of 4:15 A.M. when LPN #858 left, Resident #61 had not been located. · On 08/17/25 at 2:00 A.M. CNA #833 reported another aide approached her to say that Resident #61was missing and that she saw him at the bus stop (on 08/16/25) about 9:00 P.M. They then started looking for him. · Review of the Police Dispatch Log revealed on 08/17/25 at 8:07 A.M. Resident #61 was found at a gas station which was one-half mile from facility and a 15-minute walk. Between 8:07 A.M. and 8:10 A.M. a male in the store notified police a man was sleeping behind the store. The responding officer noted Resident #61 was awake and breathing but was unable to focus or understand questions, had possible altered mental status, was very confused, and not aware of what happened last night. · Review of the Ambulance Prehospital Care Report Summary dated 08/17/25 revealed Resident #61 was transported to a local emergency department. Resident #61 walked with assistance to stretcher. No drug use was suspected, he was psychologically impaired, with the chief complaint being altered mental status. Resident #61 was found asleep behind a gas station and had no idea how he got there, where he lived, or what happened prior to his arrival at the scene. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/27/25 the administrator provided a list of residents with wanderguards and required 1:1 supervision. The list identified Resident #13 and #31 with wanderguards and #61 with 1:1 supervision. Observation on 08/27/25 at 8:03 A.M. revealed Resident #61 in his room sleeping with an aide standing outside his door. Several attempts from 08/27/25 to 08/28/25 to interview CNA #828, who initially let Resident #61 out of the building were unsuccessful. Interview on 08/27/25 at 10:58 A.M. with the DON revealed one CNA was assigned to always supervise Resident #61 on all shifts. That CNA did not provide any care to any other residents, was not included in the count for the floor aides and was to keep eyes on Resident #61 at all times. Observation at the time of the interview revealed CNA #822 was assigned to Resident #61 and was seated in a chair on the left side of the doorway to his room. Resident #61's assigned 1:1 CNA was not included in the count for the floor aides. Interview on 08/27/25 at 2:07 P.M. with LPN #858 revealed she was not schedul

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview the facility failed to ensure progress notes were comprehensive, accurate and in chronological order for Resident #13, #25, #63, #76, and #83. This affected five (Residents #13, #25, #63, #76, and #83) of six residents records reviewed for clinical documentation. The facility census was 72. Findings include:1. Record review revealed Resident #76 was admitted [DATE] with diagnoses of local infection of the skin and subcutaneous tissue, secondary malignant neoplasm of bone, malignant neoplasm of cervix uteri, staphylococcus, Stage III pressure ulcer (full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muscle are not exposed, slough may be present but does not obscure the depth of tissue loss, may include undermining and tunneling) of the right buttock, Stage III pressure ulcer of the sacral region, and opioid dependence. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #76 was cognitively intact, dependent on staff for showers, dressing, transfers, and bed mobility, and required maximal assistance for toileting hygiene. Review of the progress notes revealed the last note was dated 07/28/25 with 07/23/25 listed as the date of service. Resident #76 was seen that day by the wound care nurse practitioner (NP) who recommended surgical debridement of the sacral wound at the hospital at which time Resident #76 refused. Interview on 09/08/25 at 11:34 A.M. with the Director of Nursing (DON) revealed Resident #76 was sent to the hospital on [DATE] for further assessment of a wound and did not return. The DON confirmed there were no status updates or discharge documented in the resident's record after the hospital transfer. Interview on 09/08/25 at 2:00 P.M. with Admissions Director (AD) #804 revealed Resident #76 was transferred to Mercy Health Hospital and then to University of Pittsburgh Medical Center (UPMC) and was subsequently discharged . AD #804 reported multiple attempts were made to reach Resident #76's spouse; however, none were documented. Follow up interview on 09/08/25 at 2:26 P.M. with AD #804 revealed the nurse was to document the admitting diagnoses whenever a resident was admitted to the hospital, and AD #804 was to track the individual while hospitalized . AD #804 reported she tracked residents that were admitted to hospitals that were in network including local hospitals. If transferred to an out of network hospital, AD #804 followed up with the family or representative for updated information. Resident #76 was initially admitted to a local hospital but then transferred to UPMC which was out of network. AD #804 confirmed she did not document any of the information in the resident record. 2. Review of Resident #13's medical record revealed diagnoses including delusional disorders, anti-social personality disorder, anxiety disorder, difficulty walking, fall and insomnia. During review of Resident #13's progress notes, it was noted some notes failed to be comprehensive and accurate. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a. A nursing note by Licensed Practical Nurse (LPN) #861 dated 05/24/25 at 7:11 P.M. indicated Resident #13 signed out leave of absence (LOA) around 3:45 P.M. stating he was going to the store. Resident #13 had not returned back yet at this time. All parties were aware. During an interview on 08/28/25 at 8:18 A.M., LPN #861 stated the parties referred to in her progress note on 05/24/25 at 7:11 P.M. was only the on-call unit manager. b. A nursing note by LPN #858 dated 05/25/25 at 10:50 P.M. indicated the nurse called the guardian to make her aware Resident #13 had signed out, left and had returned. The nurse left a voice mail requesting the guardian to call back. On 09/02/25 at 11:22, LPN #858 stated Resident #13 had not left the faciity on [DATE]. The note dated 05/25/25 at 10:50 P.M. was referring to the LOA on 05/24/25. 3. Review of Resident #25's medical record revealed an admission date of 06/09/22 with diagnoses included schizoaffective disorder, major depressive disorder (MDD), anxiety, hypertension, and the need for assistance with personal care. Review of Resident #25's quarterly MDS 3.0 assessment dated [DATE] revealed the resident had impaired cognition. She required set-up assistance with eating, substantial assistance with oral hygiene, toileting hygiene, dressing, personal hygiene and bed mobility. Resident #25 was dependent on staff for showers. Review of Resident #25's care plan dated 07/31/25 revealed she had impaired cognition related to intellectual disability and cognitive communication deficit. Staff were to administer all medications, keep routine as consistent as possible in order to decrease confusion, and staff to provide visible clocks, a calendar, low-glare, consistent care routines, familiar objects, and reduced sensory noise as much as possible. Review of Resident #25's progress notes dated 08/28/25 revealed there were no progress notes related to the incident of witnessed staff-to-resident verbal abuse on 08/25/25. Interview on 09/08/25 at 2:25 P.M. with the Administrator and with Social Service Designee (SSD) #850 revealed they confirmed no charting was completed on 08/28/25 regarding the abuse investigation, notification to physician, family or the police. 4. Review of the closed medical record for Resident #63 revealed an admission date of 07/14/25 and a discharge date of 08/28/25. Resident #63 had diagnoses including encephalopathy, anorexia, severe protein-calorie malnutrition, cognitive communication deficit, post-traumatic stress disorder (PTSD), cocaine use, adult failure to thrive, anxiety disorder, depression, hypertension, cancers of the urinary tract, nasal cavities, middle ear, and accessory sinuses, and nicotine dependence. Review of Resident #63's 5-day MDS 3.0 assessment dated [DATE] revealed the resident had impaired cognition that improved over time while at the facility to be intact. Resident #63 required setup assistance with eating, oral hygiene, and toileting hygiene, additionally she required supervision with showers and dressing and was independent with bed mobility. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #63's progress notes revealed multiple late entry notes for example note entered by LPN #585 on 07/16/25 at 1:48 A.M. effective for 07/14/25 at 8:41 P.M., entered by SSD #850 on 07/26/25 at 11:45 A.M. effective for 07/24/25 at 11:44 A.M., entered by SSD #850 on 07/26/25 at 11:52 A.M. effective for 07/25//25 at 11:51 A.M., entered by LPN #858 on 07/29/25 at 1:16 A.M. effective for 07/27/25 at 9:09 P.M., entered by LPN #902 on 08/01/25 at 1:54 A.M. effective for 07/31/25 at 1:52 A.M., entered by LPN #858 on 08/17/25 at 12:37 A.M. effective for 08/15/25 at 10:50 A.M., Additionally, there was a resident to resident incident that occurred on 08/26/25 that was not documented on in Resident #63's chart and finally a note was entered by Assisted Director of Nursing (ADON) #805 on 08/29/25 at 8:37 A.M. effective for 08/28/25 at 6:34 P.M. Interview on 08/29/25 at 12:52 P.M. with ADON #805 confirmed all examples of late documentation. Interview on 09/02/25 at 1:11 P.M. with LPN #858 and SSD #850 confirmed all examples of late documentation and stated at times, there was not enough time in the day to chart everything that happened. 5. Review of Resident #83's medical record revealed an admission date of 01/07/18 and a discharge date of 006/26/25. Diagnoses included ataxic cerebral palsy, epilepsy, anemia, thoracic aortic aneurysm, schizophrenia, obsessive compulsive disorder, MDD, and need for assistance with Activities of Daily Living (ADL) and personal care. Review of Resident #83's discharge MDS 3.0 assessment dated [DATE] revealed the resident had slight impairment of cognition, and required supervision with eating, and oral hygiene they required substantial assistance for toileting hygiene, showers, dressing, and personal hygiene. Review of Resident #83's progress notes from 04/28/25 to 06/26/25 revealed on 04/28/25 there was a urinalysis with culture and sensitivity (UA C&S) ordered with no supporting documentation as to why or who ordered it and if Resident #83's family was notified. Further review of Resident #83's progress notes revealed there were late entry progress notes entered on 06/04/25 at 2:29 P.M. effective for 05/05/25 at 2:09 P.M. and another late entry note dated 06/09/25 at 2:09 P.M. effective for 05/06/25 at 2:09 P.M. Interview on 08/27/25 at 12:45 P.M. with the DON confirmed the late entry documentation for Resident #83 for antibiotic use was completed one month later. The DON had no explanation why documentation was not completed timely. Interview on 09/08/25 at 4:22 P.M. with RN #844 revealed Resident #83 was experiencing altered mental status. She was more depressed due to a roommate change. She thought it was a behavior and ordered the UA C&S. RN #844 confirmed she did not document the behaviors the resident was having, and she did not document if she notified the NP or the Physician. RN #844 confirmed she did not notify the family of the new order for the UA C&S, nor did she document any of this information. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the undated facility policy titled Clinical Documentation Standards revealed it is the policy of the facility to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents. Safety is primary concern for our residents, staff, and visitors. Maintaining the integrity, quality, and safety of medical records can help provide effective communication between practitioners that may serve to enhance resident outcomes. This facility uses both electronic medical records and paper medical records. A complete record contains an accurate and functional representation of actual experience of the resident and must contain enough information to show that the status of the individual resident is known, and a plan of care has been identified to meet the care needs identified in the medical record. Nurses will follow the basic standard of practice for documentation including but not limited to providing a timely and accurate account of resident information in the medical record, documenting legibly in English using only acceptable medical abbreviations. The nurse is expected to document accurately, truthfully, to the best of his/her knowledge, what is heard or seen during assessments or encounters that concern the resident. They are to not document opinions or impressions, and they are to document entries during the work shift and complete all entries before leaving the facility for that shift. This deficiency represents noncompliance investigated under Complaint Number 1366500 (OH00167393).