

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365974	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER Ohio Living Quaker Heights		STREET ADDRESS, CITY, STATE, ZIP CODE 514 West High Street Waynesville, OH 45068	
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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, policy review, Emergency Medical Services (EMS) report, police report, online guidelines from American Heart Association (AHA) and review of staff witness statements, the facility failed to assess a resident for a pulse or vital signs and failed to immediately start Cardio-Pulmonary Resuscitation (CPR) for a resident who was a full code. This resulted in serious life-threatening harm and/or death on [DATE] when Resident #60 was found unresponsive. The facility staff did not check Resident #60 for a pulse and did not obtain vital signs. CPR was not started by facility staff. This affected one (Resident #60) of three residents reviewed for Full Code status and Change of Condition. The facility census was 58. On [DATE] at 12:47 P.M., the Administrator and Director of Nursing (DON) were notified that Immediate Jeopardy began on [DATE] at 12:22 A.M. when Agency Certified Nursing Assistant (CNA) #141 discovered Resident #60 in his room unresponsive and without pulse. CNA #141 summoned the nursing staff. Agency Registered Nurse (RN) #142 arrived at Resident #60's room on [DATE] at 12:25 A.M. and then exited the room [ROOM NUMBER] seconds later without assessing the resident, taking any vital signs, and without initiating CPR immediately. EMS arrived on [DATE] at 12:35 A.M and started CPR. Resident #60 was pronounced dead at the hospital on [DATE] at 1:37 A.M. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: On [DATE] at 10:30 A.M., the DON and Division Manager of Quality and Compliance (DMQC) #150 completed a retrospective review of the previous six months to identify any additional residents that experienced cardiac arrest or required CPR. No additional events were identified. The review was completed on [DATE] at 3:50 P.M. On [DATE] at 1:39 P.M., the DON notified the staffing agency leadership and the incident was discussed. All three CNAs (#141, #143 and #144) and Agency RN #142 were labeled as Do Not Return. On [DATE], the staffing agency leadership was able to obtain a witness statement from Agency RN #142, and it was sent to the facility. On [DATE] at 3:00 P.M., the DON, Assistant Director of Nursing (ADON) #74, Minimum Data Set (MDS) Licensed Practical Nurse (LPN) #120 and RN Staff Educator #138 reviewed the Emergency Response Procedures, Code Response Expectations, Emergency Response to Medical Emergencies Policy and Change in Condition policy. No changes were made. On [DATE] at 3:00 P.M. and on [DATE] at 6:50 P.M., the DON, ADON #74, and LPN #120 completed facility wide mock codes to evaluate staff response, communication, role delegation and adherence to basic life support (BLS) expectations. All staff at each mock code responded appropriately. On [DATE] at 3:45 P.M., staff education was initiated with all licensed nurses by RN Staff Educator #138 and LPN #120 on the recognition of cardiac arrest, location of crash carts, verification of code status, immediate activation of EMS, initiation of CPR for full code residents without delaying chest compressions while awaiting EMS and the facility's expectations regarding emergency response and (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	teamwork. New hires would receive this education during their orientation with RN Staff Educator #138. All agency staff would receive this education prior to the beginning of their shifts. Agency training was provided by the agency binder with a signature sheet that verified that the agency staff member reviewed and understood the information in the binder. The education was completed on [DATE] at 12:10 P.M. for all licensed nurses employed by the facility. Agency education and new hire education remained ongoing. On [DATE] at 10:36 A.M., the DON created an SRI for an allegation of neglect/mistreatment. The SRI was completed on [DATE] at 11:04 A.M. and due to the facility's findings, the agency nurse delayed resuscitative measures, and the allegation of neglect was substantiated. On [DATE] at 3:45 P.M., Cardiac/respiratory arrest audits were initiated by the DON and ADON #74 to check to see if any resident with a Full Code Status coded, required CPR, and staff initiated CPR appropriately. This will be done five times weekly for two weeks then weekly for 90 days, then monthly for three months. The findings will be reported by the administrator to the QAPI committee. On [DATE] at 8:30 A.M., portable two-way radios were purchased and placed on the units by the DON. On [DATE] at 8:30 A.M., the DON, ADON #74, LPN #120 and RN Staff Educator #138 began education on where to find the two-way radios, where the chargers were located, the channel to be on, how to operate all functions of the two-way radios, no resident information was to be given out over the radios, use in urgent situations and only give a location to send help and hand-off at the radio and the end of the shift. Training for new hires would be provided during orientation with RN Staff Educator #138 and training for agency staff would be provided in the agency binders with the agency staff members signing that they had reviewed and understood the information in the binder. On [DATE] at 4:00 P.M., all CNAs were educated by ADON #74 on the steps to take if they find a resident unresponsive. The education was completed on [DATE] at 12:00 P.M. Beginning [DATE] at 5:00 P.M., agency staff received this education by the CNA agency binder, and their signature indicated that they reviewed and understood the information in the binder. All new hires would receive the training during their orientation by RN Staff Educator #138. On [DATE] at 4:30 P.M., Agency RN #142 was reported to the Board of Nursing by the DON. On [DATE] at 8:30 A.M., ADON #74 and LPN #120 completed an audit of all current code statuses to verify physician orders and accessibility of code status information. The audit was completed on [DATE] at 1:15 P.M. There were no additional concerns identified. On [DATE] at 3:30 P.M., an ad hoc Quality Assurance Performance Improvement (QAPI) meeting was held to review the incident that occurred on [DATE] which involved Resident #60 passing away and the nurse on duty not providing CPR. The investigation was reviewed and it was determined that the nurse did not follow her responsibilities of assuring the resident received necessary life sustaining interventions. The plan of correction was reviewed. The DON, the Administrator, DMQC #150, Staff Educator #138 and Physician #160 were in attendance. On [DATE], all emergency response events will be reviewed through the facility's QAPI process to identify trends and implement additional corrective actions as indicated. On [DATE] at 6:00 P.M., the DON initiated checks at the beginning of each shift by nursing leadership to ensure the agency nurses and CNAs had reviewed and expressed understanding of the information by signing the signature sheet. The audits will be completed daily for 60 days and then weekly for 90 days. The audit findings would be taken to the QAPI meeting by the Administrator to review. On [DATE], the DON implemented a new process to check all agency nurse's CPR status prior to working in the facility. The CPR status check is completed through the staffing agency's portal. Staff Educator #138 will monitor the facility's nursing staff for current CPR certifications. The facility does not require CNAs to be CPR certified. Beginning in [DATE], mock code drills will be completed monthly for three months and then quarterly thereafter by the DON, ADON #74 or RN Staff Educator #138. The findings would be taken to the QAPI (continued on next page)		

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	room on her standard rounds and found him responsive. Agency CNA #141 stated she went to the nurses' station to find the nurse, but she was not there so she ran to grab Agency CNA #144 who was working on another unit. Agency CNA #141 stated she called Agency RN #142 when she was going to get Agency CNA #144. Agency CNA #141 stated she and Agency CNA #144 went into Resident #60's room and Resident #60 was not breathing or responding. Agency CNA #141 stated that Agency RN #142 came to the room and then came back out of the room a few minutes later and went to the nurses' station to call 911. Agency CNA #141 stated that Agency RN #142 went to grab a third CNA a few minutes later and all three CNAs were standing outside of Resident #60's room. Agency RN #142 asked who could help perform CPR and all three CNAs stated they were not certified. Review of the witness statement from Agency RN #142 dated [DATE] and recorded by the DON, revealed the DON reached out to Agency RN #142 via phone to ask questions about events that occurred on night shift on [DATE] when Resident #60 was found unresponsive. Agency RN #142 stated that Agency CNA #141 found Resident #60 unresponsive and called her to the room. Agency RN #142 arrived at Resident #60's room from the back of the unit and Agency CNAs #141 and #144 were in the doorway of Resident #60's room. Agency RN #142 stated that upon her assessment, she recognized Resident #60 did not have a pulse and she went to the nurses' station to call 911 and check his code status. Agency RN #142 stated that she asked Agency CNAs #141 and #144 if they could start CPR and they told her they were not CPR certified. Agency RN #142 then went to the back of the unit to grab CNA #143 and asked him if he was CPR certified and he said no. Agency RN #142 stated that she needed to go to the other units in the building to look for another nurse to perform CPR with her and to find a crash cart. The DON asked why she did not stay with the resident, start chest compressions and send one of the three CNAs standing there to go look for another nurse and to grab the crash cart and Agency RN #142 stated that she went because she knew where things were and was not sure if they did. The DON asked why Agency RN #142 did not start chest compressions and Agency RN #142 stated she was not sure if Resident #60 may have still had a thready pulse and he was still warm. Agency RN #142 stated that she put in her note that Resident #60 was unresponsive, and never said he was pulseless. Review of the facility's self-reported incident (SRI) was created on [DATE] at 10:36 P.M. for an allegation of abuse/neglect/mistreatment discovered on [DATE]. An internal investigation was ongoing regarding the actions of Agency RN #142 in response to a resident who was found unresponsive in the early hours of [DATE]. During the investigation, conflicting information was obtained from Agency RN #142 regarding the events surrounding the incident. On [DATE], Agency RN #142 was contacted as part of the facility's follow-up investigation on the new information. During that conversation, Agency RN #142 stated that CPR was not initiated while waiting for EMS to arrive because Agency RN #142 was unsure whether Resident #60 had a pulse and she believed she may have felt a weak, thready carotid pulse. When EMS arrived at the facility, they initiated CPR and were able to resuscitate Resident #60 and transfer the resident to the hospital. On [DATE], Agency RN #142 was contacted again and requested to provide a written statement. Agency RN #142 refused to provide a written statement and stated that she never said she was unsure if he had a pulse or not, which conflicted with the information documented during the previous follow-up conversation. The SRI was substantiated as neglect/mistreatment was verified by evidence. Review of Agency RN #142's witness statement dated [DATE] at 11:04 P.M., revealed Agency RN #142 received a call on her phone from Agency CNA #141. Agency CNA #141 informed Agency RN #142 that she heard audible noises coming from inside Resident #60's room. Agency CNA #141 entered the room to check on Resident #60 and found him unresponsive. Following the phone contact, Agency RN #142 responded immediately and arrived at Resident #60's room. When Agency RN #142 entered the room, (continued on next page)		

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Agency RN #142 found Resident #60 unresponsive and observed very shallow respirations. Agency RN #142 also observed his supplemental oxygen cannula was hanging off his face and was out of his nose. Based on Agency RN #142's nursing assessment at that time, Agency RN #142 believed Resident #60 was still exhibiting signs of life and required immediate emergency medical intervention. Agency RN #142 did not believe the resident was pulseless at the time of the assessment. Agency RN #142 immediately contacted EMS and obtained advanced medical assistance as quickly as possible and simultaneously obtained the resident's code status. While EMS was in route, Agency RN #142 notified available staff and directed them to lower the head of the bed and place the bed flat in preparation for the possibility that CPR could become necessary. Agency RN #142 instructed staff to prepare for an emergency response. The staff members present stated they were not CPR certified. Agency RN #142 had to temporarily leave the immediate area to secure qualified staff and emergency equipment because Resident #60's room and the unit lacked a facility wide emergency alert system to instantly summons qualified clinical assistance, and crash carts were not visible or readily identifiable on the unit. Agency RN #142 personally left the unit because she was familiar with the wider facility layout, knew the nurses on the other units and knew the access codes between the units. Based on Agency RN #142's familiarity with the building, she believed that she could obtain necessary resources more quickly than by directing non staff members who were unfamiliar with the facility to do so. At every point during the event, Agency RN #142's actions were guided by her clinical assessment that Resident #60 required the fastest possible emergency response and rapid access to advanced medical care. EMS arrived shortly thereafter and assumed care of Resident #60. Agency RN #142's subsequent electronic nursing documentation that stated CPR was initiated was to log that CPR occurred during the course of the overall emergency response and it was not intended to indicate that CPR was active or necessary at the exact moment of Agency RN #142's initial bedside assessment. Agency RN #142 did not recall the exact verbatim phrasing during the EMS call due to the high acuity nature of the emergency and Agency RN #142's focus was entirely on communicating clinical urgency to secure rapid EMS response. During an interview on [DATE] at 11:25 A.M., Paramedic #151 reported the call initially came in on [DATE] and the caller reported the facility had an unresponsive resident, and the caller thought the resident had passed away. Paramedic #151 stated they were dispatched to the facility on [DATE] at 12:27 A.M. and EMS arrived at approximately 12:32 A.M. Paramedic #151 reported that the police were on scene at the facility upon arrival of EMS. Paramedic #151 stated that EMS arrived at Resident #60's room and there were three employees standing around with Resident #60 being situated along the back wall of his room but there were no staff touching Resident #60 or performing CPR on Resident #60. Paramedic #151 stated Resident #60 was blue in color, unresponsive and had no signs of life. Paramedic #151 reported Resident #60 was lying flat on his back in bed. Paramedic #151 reported Resident #60 was cool to the touch but was not stiff. Paramedic #151 stated he started CPR and there were no signs that the facility had attempted CPR prior to EMS arrival as Paramedic #151 cracked Resident #60's ribs. Paramedic #151 reported he rotated chest compressions with Police Officer #149 while Paramedic #152 did ventilations. Paramedic #151 stated that there were four to five nursing facility employees present and he asked if anyone was CPR certified to help EMS with chest compressions and all the nursing facility employees said no. Paramedic #151 reported that none of the staff indicated that they were a nurse or that there were nurses present at the building. Paramedic #151 reported EMS got Resident #60's pulse back and EMS initiated transport to the hospital at approximately 1:08 A.M. Paramedic #151 stated EMS lost Resident #60's pulse in route to the hospital approximately five minutes into transport. Paramedic #151 stated EMS arrived at the hospital approximately 15 to 20 (continued on next page)		

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	minutes later and Resident #60 was without a pulse upon arrival at the hospital. Paramedic #151 stated that Resident #60 was taken into a trauma bay and the hospital worked on him for approximately ten minutes before they called time of death. During an interview on [DATE] at 11:34 P.M., Paramedic #152 reported EMS was dispatched to the facility on [DATE] and upon arrival, there were three staff members just standing along the back wall of Resident #60's room and no one was performing CPR. Paramedic #152 stated Resident #60 was lying on his back in bed and his face was blue. Paramedic #152 stated that EMS started CPR as they asked for any information on Resident #60 and no one could give them Resident #60's age. Paramedic #152 reported the staff were asked if they were CPR certified to assist with doing chest compressions and all the staff stated that they were not certified to perform CPR. Paramedic #152 stated EMS was able to get a pulse back but became pulseless again as they transported Resident #60 to the hospital. Paramedic #152 stated the facility staff indicated Resident #60 was a full code and there were no signs that CPR was started prior to EMS arrival at the facility. During an interview via telephone on [DATE] at 2:00 P.M., Agency Licensed Practical Nurse (LPN) #146 stated she worked at the facility on [DATE] when Resident #60 was found unresponsive without respirations. Agency LPN #146 stated she was not informed of the situation until after EMS arrived and had initiated CPR on Resident #60. During an interview via telephone on [DATE] at 2:37 P.M., Agency RN #142 stated Agency CNA #141 heard Resident #60 making noises in his room and she went into the resident's room to check on him and found him unresponsive. Agency RN #142 stated Agency CNA #141 called Agency RN #142 to the resident's room and Agency RN #142 went to Resident #60's room and found him with his oxygen nasal canula hanging out of his nose. Agency RN #142 stated she observed Resident #60 take one shallow breath and she immediately left Resident #60's room to get his code status and to call EMS. Agency RN #142 stated she left the unit after she called EMS to round up resources including another nurse and a crash cart. Agency RN #142 stated she was not sure where the crash carts were located in the facility. Agency RN #142 reported she walked past a nurse while she was looking for resources, but the nurse was busy with a colostomy so she did not even tell the nurse about the situation because she thought explaining it to her would take forever. Agency RN #142 stated she found another nurse and took her back to the unit, but EMS had already arrived at the facility by the time she got back to the unit. Agency RN #142 verified she never took Resident #60's pulse or vitals. Agency RN #142 reported she instructed the CNAs on the unit to lay Resident #60's bed flat prior to her leaving the unit to gather resources. Agency RN #142 stated she asked the CNAs if they were CPR certified and they stated no. Agency RN #142 denied EMS ever asking if she was CPR certified. Agency RN #142 verified no staff performed CPR on Resident #60 from the time he was found by Agency CNA #141 until EMS arrived at the facility and that no pulse or vitals were taken during that time. During an interview via telephone on [DATE] at 2:48 P.M., Agency CNA #143 stated he worked at the facility on [DATE] when Resident #60 was found unresponsive by Agency CNA #141. Agency CNA #143 stated he followed Agency RN #142 to Resident #60's room around 12:00 A.M. and a couple of other CNAs were standing outside of Resident #60's room and everyone was trying to find out what was going on. Agency CNA #143 reported he stepped by Resident #60's door and saw Resident #60 lying in bed, but he could not give any additional details. Agency CNA #143 stated that he did not remember anyone going in Resident #60's room and he did not really pay attention to what Resident #60 looked like in the room. Agency CNA #143 stated the police arrived and spoke to Agency RN #142 and EMS arrived and initiated CPR. During an interview via telephone on [DATE] at 2:58 P.M., Agency CNA #144 stated she went into Resident #60's room because she heard moaning noises coming from the resident's room during rounds. Agency CNA #144 stated Agency CNA #141 found Resident #60 unresponsive and he was not (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Ohio Living Quaker Heights		STREET ADDRESS, CITY, STATE, ZIP CODE 514 West High Street Waynesville, OH 45068	
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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	breathing. Agency CNA #144 stated Agency CNA #141 called the nurse and went to find her. Agency CNA #144 stated Agency CNA #141 thought Resident #60 was deceased and Agency CNA #141 called her to the resident's room to see if Resident #60 was deceased . Agency CNA #144 stated she went in Resident #60's room and reported that Resident #60 appeared deceased , was not breathing, was warm to the touch and pale. Agency CNA #144 stated Agency RN #142 came to the room, looked at Resident #60 and then immediately left the room and called EMS. Agency CNA #144 stated Agency RN #142 never touched Resident #60 or took his vitals during the entire incident and never did CPR on the resident. Agency CNA #144 stated the police arrived at the facility first and Police Officer #149 reported Resident #60 had no pulse and that was the first time that Resident #60's pulse was taken during the incident. Agency CNA #144 reported Police Officer #149 asked Agency RN #142 what Resident #60's code status was and Agency RN #142 stated she didn't even think of that. Agency CNA #144 reported Agency RN #142 got on the computer and found out that Resident #60 was a full code, but EMS had arrived and started CPR by that time. Agency CNA #144 stated EMS asked the Police Officer #149 to help do chest compressions on Resident #60. Agency CNA #144 stated that EMS asked if anyone could help do CPR and Agency CNA #144 reported all the CNAs reported they were not certified to do CPR. Agency CNA #144 reported that Agency RN #142 told her that no one could help because the other nurse was busy doing a colostomy bag and Agency CNA #144 stated she did not understand why Agency RN #142 did not have the other two nurses at the facility help. Agency CNA #144 also reported that no one ever called a Code Blue or the facility's code for an unresponsive resident in need of CPR. Agency CNA #144 stated the facility did not have any way to communicate emergencies and the nurse never asked her or the other CNAs to do any tasks such as find the crash cart, get help or call EMS. Agency CNA #144 reported Resident #60 was without respirations for 10 to 15 minutes from the time Agency CNA #141 found Resident #60 unresponsive to the time EMS arrived at the facility and initiated CPR. During an interview via telephone on [DATE] at 3:19 P.M., Agency CNA #141 stated she was doing her rounds around midnight, and she thought she heard Resident #60 cough in his room. Agency CNA #141 stated she went into the resident's room, called out for the resident and rubbed the resident's legs. Agency CNA #141 stated that Resident #60 did not respond and she yelled for help. Agency CNA #141 stated she ran to another unit and told Agency CNA #144 to come help because Resident #60 was unresponsive. Agency CNA #141 stated Agency CNA #144 asked where the nurse was, and she called Agency RN #142. Agency CNA #141 could not recall if any nursing staff checked Resident #60's pulse or vitals. Agency CNA #141 stated Agency RN #142 arrived at Resident #60's room,[TRUNCATED]		

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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. Based on staff interview and record review, the facility failed to ensure residents received showers per their preference. This affected one (#46) out of three residents reviewed for activities of daily living. The facility census was 58. Findings include: Review of the medical record for Resident #46's revealed an admission date of 06/02/26. Diagnoses included encephalopathy, dementia unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, altered mental status, thrombocytopenia, hypertension, and benign prostatic hyperplasia without lower urinary tract symptoms. Review of Resident #46's progress notes from 06/02/26 to 07/20/26, revealed Resident #46 did not refuse any showers documented in the chart. Review of Resident #46's shower sheets from 06/02/26 to 07/20/26, revealed Resident #46 received a shower on 06/12/26, 06/19/26, 07/10/26, and 07/14/26. Review of the admission Minimum Data Set (MDS) assessment for Resident #46 dated 06/08/26, revealed the resident was severely cognitively impaired and required moderate assistance with, showering. Review of the activities of daily living (ADL) care plan for Resident #46 dated 06/13/26, revealed the resident had an ADL self-care performance deficit related to encephalopathy and dementia. The resident required one to two staff assistance with bathing and showering and to provide a sponge bath when a full bath or shower could not be tolerated. Interview on 07/21/26 at 10:48 A.M. the Director of Nursing (DON) verified Resident #46 had no documented showers from 06/02/26 to 06/11/26, from 06/13/26 to 06/18/26, from 06/20/26 to 07/09/26 and from 07/15/26 to 07/30/26. The DON confirmed Resident #46 was scheduled to receive showers two times per week at the facility. Review of the facility's resident centered care bathing choice policy dated 01/26/26 revealed residents are informed that they would be offered bathing twice a week during the admission process. Residents are asked if they have a different preference for bathing. This deficiency represents non-compliance investigated under Complaint Number 3073748.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to implement appropriate fall interventions and the facility failed to ensure a resident's fall intervention was in place. This affected one (#31) resident out of three residents reviewed for falls. The facility census was 58. Findings include: Review of medical record for Resident #31's revealed an admission date of 09/01/21. Diagnoses included Alzheimer's disease, iron deficiency anemia, age-related physical debility, muscle weakness, other abnormalities of gait and mobility, and hypertension. Review of a physician order for Resident #31 dated 01/23/26, revealed staff were to ensure the resident was wearing non-slip socks or shoes while ambulating. Review of the quarterly Minimum Data Set (MDS) assessment for Resident #31 dated 07/06/26, revealed the resident to be severely cognitively impaired, required supervision with eating and rolling left and right. Resident #31 required moderate assistance with sitting to lying, lying to sitting, sitting to standing, chair transfers, toilet transfers, tub transfers and walking ten feet and maximal assistance with oral hygiene, showering, upper body dressing, and personal hygiene. Resident #31 was dependent with toileting, lower body dressing, and putting on and taking off footwear and Resident #31 had one fall with no injury on the MDS. Review of the fall risk assessment for Resident #31 dated 02/23/26, revealed Resident 31 was at high risk for falls. Review of the progress note for Resident #31 dated 03/27/26 at 4:13 P.M., revealed the resident was lowered to the floor by staff. Resident #31 had been changed and helped to bed by staff. At that point, Resident #31's shoes were taken off and socks were only worn. Resident #31's bed was low but not in the lowest position. Resident #31 got out of bed and the staff member was helping Resident #31 back into the bed. Resident #31 slipped and was lowered to the floor. The physician, Director of Nursing (DON) and power of attorney (POA) were notified. A new order was given to ensure Resident #31 was wearing non-skid socks at all times. Resident #31 was uncooperative with vitals. Range of motion was within normal limits and Resident #31 showed no signs of pain. No injuries were noted. Review of the fall investigative summary for Resident #31 dated 03/27/26 at 4:13 P.M., revealed the Certified Nursing Assistant (CNA) removed Resident #31's shoes and the resident only had her socks on when she got out of bed by herself. The CNA saw Resident #31 and went back into her room and began assisting her back to bed when Resident #31 slipped and the CNA had to lower her to the floor. The immediate intervention was a new order to ensure the resident was wearing non-skid socks at all times when not wearing shoes. Review of the fall care plan for Resident #31 dated 04/14/26, revealed the resident was at risk for falls related to previous falls, risk factors determined on the fall risk assessment, disease process and conditions, functional problems, and medication use. Interventions included non-skid socks at all times, non-skid socks during overnight hours and ensure the resident wore non-skid socks or shoes when ambulating. Review of the progress note for Resident #31 dated 07/06/26 at 4:14 P.M., revealed the nurse heard a loud thud at around 4:00 P.M. Resident #31 was found in the hallway near the dining room. Resident #31 had a hematoma noted on the right forehead. Resident #31's left hand had a large gash on the lateral pinky or fifth finger. Resident #31 was at her cognitive baseline. Resident #31 was uncooperative with care. Resident #31's hand was cleansed and was wrapped. Resident #31 removed treatment two times. Ice was applied to the right forehead. The physician, DON and POA were made aware. Review of the fall investigative summary for Resident #31 dated 07/05/26 at 4:00 P.M., revealed the resident was exiting a room at the end of the hallway when she stumbled and fell to the floor. Resident #31 hit her head. Resident #31 was assessed by staff who (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	noted a hematoma developing to the right side of her forehead and a laceration to the fifth finger on the left hand. The injuries were tended to and the resident was placed on neurological (neuro) checks as she was at cognitive baseline subsequent to the fall. Resident #31 was assisted off the floor by staff and taken to a nearby chair in the common area for further evaluation and monitoring. Resident #31's most recent Brief interview for Mental Status (BIMS) was unable to be completed due to her cognition. Resident #31 had socks on at the time of the fall, and she was at risk for falls due to vascular dementia, age related physical debility and hypertension. The immediate intervention was to ensure the resident was wearing proper footwear while ambulating. Review of the fall investigative summary for Resident #31 dated 07/10/26 at 6:30 P.M., revealed the resident was ambulating in the common area when she cried out after falling to the floor. Resident #31 attempted to sit on the arm of a nearby chair. Resident #31 was found on the floor in the supine position and attempted to get back to her feet independently. Staff intervened and assessed Resident #31 and no new injuries were noted. Resident #31's range of motion and vitals were within normal limits. Resident #31 was assisted back to her feet and began ambulating again without difficulty. Resident #31's most recent BIMS was unable to be completed due to cognitive functioning secondary to dementia. Resident #31 was at risk for falls due to fall history, dementia and hypertension. Immediate interventions included resident education, and reinforcement on safe sitting. Follow up interventions included frequent checks and monitoring. Review of the progress note for Resident #31 dated 07/10/26 at 7:12 P.M., revealed the staff heard a thud during shift change and Resident #31 was calling out upon entering the common area. Resident #31 was observed on her back beside a tipped over recliner. Resident #31 appeared alert and was moving all extremities. Passive range of motion was tolerated well with no signs of shortening or rotation of extremities. Resident #31 was assisted from the floor easily with assistance of two staff members. Resident #31 immediately resumed ambulating with staff monitoring for her safety. Resident #31 was observed attempting to sit on the arm rest of another recliner and staff were able to intervene to prevent a second fall. Review of the fall risk assessment for Resident #31 dated 07/10/26, revealed the resident was at high risk for falls. Observation of Resident #31 on 07/20/26 at 8:39 A.M., revealed the resident was lying in bed. Resident #31 appeared clean and dressed appropriately and was not able to be interviewed due to cognition. Interview on 07/21/26 at 10:37 A.M., the DON verified Resident #31 fell at the facility on 03/27/26 and the resident's fall intervention was to wear non-skid socks at all times when not wearing shoes. The DON confirmed Resident #31 fell on [DATE] while ambulating with regular socks in place. The DON verified Resident #31's fall intervention of non-skid socks were not in place at the time of Resident #31's 07/05/26 fall. The DON also verified education was provided on safe sitting after Resident #31's fall on 07/10/26 despite Resident #31 being severely cognitively impaired with a diagnosis of dementia. Review of the facility's fall prevention and management policy dated 01/28/25, revealed fall risk screening will be completed upon admission and quarterly. Interventions will be put in place based on risk factors. At the time of the fall, the facility will implement an immediate intervention. The interdisciplinary team will conduct a daily fall meeting to determine the best long term fall interventions for the resident. This deficiency represents non-compliance investigated under Complaint Number 3075526.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview and record review, the facility failed to ensure a resident's medical record was accurate and free from falsified information. This affected one (#60) of the three residents reviewed for accuracy of records. The facility census was 58 Findings include: Review of medical record for Resident #60 revealed an admission date of 06/30/26. Diagnoses included multiple fractures of ribs left side, fall on or from other stairs and steps, acute respiratory failure with hypoxia, acute respiratory failure with hypercapnia, type two diabetes mellitus with diabetic peripheral angiopathy, congestive heart failure (CHF), peripheral vascular disease (PVD), unilateral primary osteoarthritis left knee, and atherosclerotic heart disease of native coronary artery without angina pectoris. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #60 was cognitively intact. Review of the vital signs documentation dated 07/11/26, revealed Agency Registered Nurse (RN) #142 entered a pulse of 66 beats per minute and a blood pressure of 119 millimeters of mercury (mmHg) over 70 mmHg on 07/11/26 at 7:32 P.M. and Agency RN #142 entered a pulse of 66 beats per minute, a blood pressure of 119 mmHg over 70 mmHg and respirations of 18 breaths per minute on 07/11/26 at 7:32 P.M. Review of the facility's security footage from 07/11/26 from 6:50 P.M. to 12:22 A.M. on 07/21/26 at 11:20 A.M. with the Director of Nursing (DON), revealed Agency RN #142 came on shift on 07/11/26 at 6:55 A.M. The Certified Nursing Assistant (CNA) working on the unit was observed to enter Resident #60's room on 07/11/26 at 7:05 P.M. but there were no signs that the CNA took Resident #60's vitals as she did not have the facility's vital sign machine with her. Agency RN #142 was observed taking medication into Resident #60's room on 07/11/26 at 7:36 A.M. Agency RN #142 was in Resident #60's room for approximately 30 seconds prior to leaving the room and the video footage showed no evidence that Agency RN #142 took Resident #60's vitals at that time as Agency RN #142 did not have the vital sign machine with her. Further review of the video footage revealed Agency RN #142 went into Resident #60's room again on 07/11/26 at 8:50 P.M. for several seconds but there was no evidence that Resident #60's vitals were taken at that time as Agency RN #142 did not take the vital sign machine with her in the room. Agency RN #142 did not make any additional visits to Resident #60's room on 07/11/26 from 6:50 P.M. to 07/12/26 at 12:25 A.M. During an interview on 07/21/26 at 11:20 A.M., the DON verified none of the facility staff present on 07/11/26 from 6:55 A.M. to 07/12/26 at 1:02 A.M. took Resident #60's vitals despite Agency RN #142 entering a pulse of 66 beats per minute and a blood pressure of 119 mmHg over 70 mmHg on 07/11/26 at 7:32 P.M. and Agency RN #142 entering a pulse of 66 beats per minute, a blood pressure mmHg of 119 over 70 mmHg and respirations of 18 breaths per minute on 07/11/26 at 7:32 P.M. in Resident #60's medical record. During an interview via telephone on 07/22/26 at 8:40 A.M., Agency RN #142 verified she did not take any vital signs on Resident #60 her entire shift despite Agency RN #142 entering a pulse of 66 beats per minute and a blood pressure of 119 mmHg over 70 mmHg on 07/11/26 at 7:32 P.M. and Agency RN #142 entering a pulse of 66 beats per minute, a blood pressure of 119 mmHg over 70 mmHg and respirations of 18 breaths per minute on 07/11/26 at 7:32 P.M. in Resident #60's medical record. Agency RN #142 stated Unofficially off the record, if she didn't have machinery, she did not like to palpate a pulse and during her entire nursing career,, she always got a false pulse because she felt her pulse, but she could see a pulse.		