STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366039	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Point Place	6101 N Summit St Toledo, OH 43611

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 observation, record review, review of emergency medical services (EMS) run reports, review of crash cart audit logs, review of cardiopulmonary resuscitation certification documentation, review of a medication administration audit report, review of a vital documentation audit report, review of the American Heart Association (AHA) guidance for adult Cardiopulmonary Resuscitation (CPR), staff interview, EMS staff interviews, and review of facility policy, the facility failed to provide Resident #77, who had a full code status (advance directives), with basic lifesaving interventions on [DATE] by not immediately initiating rescue breathing or ventilations while performing chest compressions. Licensed Practical Nurse (LPN) #200 failed to immediately call 911 and/or instruct another staff member to call 911 until after the resident was assessed with an absence of vital signs, after checking code status, after taking the crash cart to the resident's room and after beginning chest compressions. After beginning chest compressions, LPN #200 then instructed Certified Nursing Assistant (CNA) #309 to call 911. Review of the EMS run report revealed the 911 call was received at 8:06 P.M. and EMS arrived at the resident at 8:18 P.M. When EMS arrived, they found staff administering chest compressions without ventilations. Resident #77 was without ventilations for greater than 12 minutes. EMS continued chest compressions and initiated ventilation and continued life-sustaining efforts. After collaboration with the off-site physician, the resident was pronounced deceased by EMS at 8:57 P.M. This affected one (Resident #77) of three residents reviewed for death. The facility identified 52 residents with a full code status. The facility census was 76.On [DATE] at 11:35 A.M., the Administrator, the Director of Nursing (DON), and the Regional Quality Assurance Registered Nurse (RQARN) #730 were notified Immediate Jeopardy began on [DATE] at 7:30 P.M. when the facility failed to provide Resident #77, who had a full code status, with basic lifesaving interventions by not immediately initiating rescue breathing or ventilations while performing chest compressions and failed to immediately call 911 and/or instruct another staff member to call 911 until after the resident was assessed with an absence of vital signs, after checking code status, after taking the crash cart to the resident's room and after beginning chest compressions. Although the Immediate Jeopardy was removed on [DATE], the deficiency remained at a Severity Level 2 (no actual Harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was in the process of implementing their corrective action plan and were monitoring to ensure on-going compliance. On [DATE] at 3:45 P.M., an Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting was held with the Administrator, DON, Medical Director #700, [NAME] President of Operations (VPO) #712, and RQARN #730. On [DATE], the DON and/or designee audited the code status of all residents. On [DATE], the DON and/or designee audits code status with physician orders and resident care plans for all residents. On [DATE], the Human Resource Director (HRD) #343 audited CPR certifications for facility nursing staff. On [DATE], the DON and/or designee re-educated the facility nurses on where to find resident code status and appropriate response in code situations. No nurse would be permitted to work after this date until the education was completed. Beginning [DATE], the DON and/or designee would audit all new admission to ensure (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	with supplemental oxygen at 15 liters per minute. A second EMS crew responded and started Advanced Life Support (ALS) Cardiac Arrest Protocols and the resident was placed on the auto ventilator. The resident was too small for the LUCAS (portable mechanical device for automatic chest compressions). Resident #77 was given four rounds of epinephrine every 10 minutes, and one dose of sodium bicarbonate. The resident was in asystole through the entire event. Manual compressions continued on the resident with EMS changing personnel every two minutes. EMS noted the facility staff had stated the resident's last known well time was approximately 6:30 P.M. EMS noted Resident #77 had an unwitnessed arrest with an approximate onset time of 6:45 P.M. The physician was contacted and later directed EMS to stop lifesaving efforts. The resident was pronounced dead at 8:57 P.M.Review of the crash cart audit logs for the crash cart located on the 100 hall and for the crash cart located on the 200/300 halls revealed there were three CPR mouth shields located in each cart and each cart contained a bag valve mask. Review of a medication audit time report dated [DATE] revealed LPN #200 last administered medication to Resident #7 on [DATE] at 8:01 P.M. and viewed Resident #25's medication record before being logged out of the electronic medical record program at 9:18 P.M. During an observation on [DATE] at 9:27 A.M. the 100-hall crash cart and the 200/300 hall crash cart with each had a bag valve mask on the crash cart and three CPR mouth shields which could be used for rescue breathing during CPR. During an interview on [DATE] at 12:52 P.M., LPN #200 stated on [DATE] after completing the shift-to-shift report, she had checked Resident #77's vital signs then went down the hall and started the evening medication pass. LPN #200 stated she was unsure of the time but estimated a few minutes later around 7:30 P.M., a nursing assistant reported Resident #77 had coded. LPN #200 thought the nursing assistant was talking about a door code then realized the nursing assistant was saying Resident #77 had coded, but it had not registered immediately because she had just seen the resident. LPN #200 grabbed the crash cart and went to the resident's room. She attempted to get Resident #77's vital signs but there were none. She had applied her personal pulse oximeter, but it was reading dash, dash, dash and she kept pushing the button on the pulse oximeter every couple of minutes trying to get a reading. She started chest compressions and told another staff member to call 911. LPN #216 went and got the AED machine and applied the AED pads to the resident. LPN #200 stated only chest compressions were administered until EMS arrived. The AED pads were too close together and they had to be moved around. LPN #200 stated we just followed the prompts. LPN #200 stated they did not provide ventilations to Resident #77 with the bag valve mask and did not provide rescue breathing. LPN #200 stated the bag valve mask was not on the crash cart and must have fallen off when bringing the crash cart to the room. LPN #200 stated the mask was later located on the floor in the room but never used. LPN #200 stated the bag valve mask looked different than ones she had seen before as it had a tube coming out of it and LPN #216 and herself did not know how to use it. It took about 15 minutes or more for EMS to arrive. By the time the bag valve mask was found on the floor, and they figured out how to put together the bag valve mask to use, EMS had arrived and took over the code. LPN #200 revealed she was not sure when the code started or when EMS arrived. LPN #200 stated she had not been trained on using the facility's bag valve mask. She did not document anything in the medical record until the following day because she was unsure what she needed to do and what needed documented. LPN #200 stated she called the DON, but she never answered so she then notified the on-call manager, RN #513 about Resident #77. LPN #200 stated she charted the incident the following day and verified the documented times were not accurate. During an interview on [DATE] at 1:30 P.M., LPN #216 stated she was notified by LPN #200 that Resident #77 had coded. LPN #216 stated chest compressions were initiated, and the AED was applied and an unknown staff member called 911. Chest compressions continued for about 15 minutes until EMS arrived and took over. LPN #216 stated LPN #200 and herself had only completed chest compression and had not provided ventilations for the resident with the bag valve mask or rescue breathing. LPN #216 denied any problems with the bag valve mask. LPN #216 stated CPR was performed with the resident on the bed with the [NAME] (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	board underneath her. She could not recall what time the code was called but the shift started at 6:45 P.M. and shift to shift report ended around 7:15 P.M. LPN #216 staed the code was called sometime after the end of report fairly early into the shift. During an interview on [DATE] at 2:05 P.M., the DON stated she had not obtained staff statements regarding Resident #77's death and had not documented interviews with the staff regarding Resident #77's death. She had talked to the staff that night and the next morning. The DON stated LPN #200 and LPN #216 had told her EMS was there, what supplies they had used on the crash cart, and what notifications were made. She had asked staff if they had used the [NAME] board under the resident while performing CPR and they had indicated they had. The nurses were asked when the last time the resident was checked and the nurse told her vitals were obtained on [DATE] at 7:20 P.M. The DON stated Resident #77 had yet to be administered any of her evening medications on [DATE]. The DON stated if a code was called then staff should check code status, check vital signs, call 911, grab the crash cart and [NAME] board, apply the AED, throw the pulse oximeter on, notify the physician and family. One nurse should be giving ventilations with the bag valve mask, and the other nurse should be doing the chest compressions, and the two nurses should switch as needed. If a bag valve mask was not available or functioning, then staff should provide rescue breathing. The DON verified there were CPR mouth shields in the crash cart. The DON also revealed the nursing staff had not reported failure to provide ventilations and/or rescue breathing for Resident #77. Attempts were made to interview LPN #316 on [DATE] at 11:19 A.M. and on [DATE] at 2:32 P.M. but were unsuccessful. During an interview on [DATE] at 11:23 A.M., CNA #222 stated Resident #77 was checked on sometime after dinner and the resident was not moving and not breathing. CNA #222 stated the resident's call light was not on. CNA #222 was unsure of the resident's assigned CNA's name. CNA #222 stated the nurse was notified but CNA #222 could not recall the nurse's name. Someone called 911 but she was unsure who had placed the call. During an interview on [DATE] at 1:21 P.M., CNA #309 stated she was assigned to Resident #77 on [DATE]. She had provided incontinence care for the resident around 4:50 P.M. then checked on the resident sometime after dinner time and repositioned the resident. CNA #309 stated Resident #77 was sweaty like usual, and she removed the blanket and covered the resident with the sheet. CNA #309 asked a coworker to check the resident as she was finishing up with other residents. CNA #309 said CNA #222 told her Resident #77 had coded. CNA #309 said she yelled for the nurse and told her the resident coded but the nurse was not understanding what she was saying. She yelled for the nurse to come now to the resident's room. Another nurse came down the hallway, and it took the nurses about 10 minutes to find the resident's code status. They went to the resident's room and LPN #200 started chest compressions. CNA #309 stated she ran and got another nurse. LPN #216 went and got the AED machine and hooked it up. LPN #200 told her to call 911. CNA #309 stated she was not sure what time she called 911. The nurses administered chest compression until EMS arrived but did not administer ventilations. During an interview on [DATE] at 10:19 A.M., Emergency Medical Technician (EMT) #500 stated they arrived at 8:18 P.M. and Resident #77 was not responsive. The resident was in her bed, and staff were performing chest compressions only. EMT #500 revealed staff were not providing ventilations with the BVM. EMT #500 revealed there was a [NAME] board under the resident. EMT #500 could not recall if there was a pulse oximeter applied to the resident. EMT #500 revealed there were three staff in the room who had not identified themselves. EMT #500 revealed the staff provided a last known well time of 5:30 P.M. then another staff stated a last known well time of 6:30 P.M. EMT #500 stated the nursing staff had not reported obtaining vital signs on the resident at 7:20 P.M. A new AED was attached to the resident, and compressions began with another EMT getting the airway ready and providing ventilation with bag valve mask with supplementing oxygen at 15 liters per minute. The ALS team arrived shortly after and started an intraosseous (IO) line and administered medications. EMT #500 stated the resident was too small for the LUCAS device to give automatic compressions. EMT #500 revealed CPR continued until the physician authorized ending resuscitation attempts.During an interview on [DATE] at 10:47 A.M., EMT #502 stated EMT #500 was first on (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	scene performing CPR on the resident. EMT #502 stated the facility staff were poor historians and had difficulty establishing the resident's last known well time. EMT #502 revealed the nursing staff never reported the resident's vitals were last obtained at 7:20 P.M.Review of the CPR Certification documentation revealed LPN #200 had received certification for Basic Life Support (BLS) and CPR on [DATE] with a renewal date of [DATE]. LPN #216 had also received certification for BLS and CPR on [DATE] with a renewal date of 04/2028.Review of the facility policy titled Documentation in the Medical Record, dated [DATE], revealed each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Licensed Staff and interdisciplinary team members would document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy.Review of the facility policy titled CPR-Medical Emergency, dated [DATE], revealed if a resident experienced a cardiac arrest, the facility must provide basic life support, including CPR prior to the arrival of EMS. The employee who first witnessed or who was first on site of the medical emergency that was trained would initiate immediate action, including CPR as appropriate, basic first aid, and summon for assistance. The nurse would assess the situation, stay with the resident, designate a staff member to announce a Code Blue, notify the physician and call 911 as needed. Further review of the policy revealed no procedure for performing CPR and providing ventilations with a BVM or rescue breaths. Review of the American Heart Association (AHA) 2025 guidance for adult CPR included the following: Check for breathing, if the person is not breathing or only gasping, begin CPR; Chest compressions included to push down hard and fast at a rate of 100 to 120 compressions per minute; After every 30 compressions, give two rescue breaths; and make sure the person is on a firm surface. In 2008, after the publication of several studies looking at the rates of bystander CPR and public attitudes toward it, the AHA updated their guidance and decided to take out rescue breathing (mouth to mouth) for untrained or lay responders as a way to encourage and focus on hands only CPR. This updated guidance did not apply to trained healthcare professionals. AHA guidelines clearly state that CPR must continue until a licensed provider with higher authority assumes care, the patient shows signs of life, the rescuer is physically unable to continue or an advanced directive/valid do not resuscitate (DNR) is present. Conditions under which CPR should not be started included decapitation, dependent lividity (pooling of blood in the lowest parts of the body) and rigor mortis (post-mortem muscle stiffening typically beginning two to four hours after death). Further review of the guidelines revealed chest compressions with ventilation improved outcomes for adults in cardiac arrest. Delivery of chest compressions without assisted ventilation for prolonged periods could be less effective than compression plus ventilation because arterial oxygen content decreased as CPR duration increased.This deficiency was an incidental finding investigated during the course of a complaint investigation.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of weekly skin assessments, resident interview, staff interview, and review of facility policy the facility failed to ensure routine skin assessments were completed and physician ordered wound interventions were implemented. This affected two (#29 and #12) of three residents reviewed for wounds. The facility identified a total of 18 residents as having wounds. The facility census was 76.Findings include:1. Review of Resident #29's medical record revealed an admission date of 11/04/25. Diagnoses included chronic kidney disease stage four, vascular dementia, major depressive disorder, dysphagia, chronic or unspecified peptic ulcer with hemorrhage, vitamin D deficiency, hypertension, and hypothyroidism.Review of the significant change Minimum Data Set (MDS) assessment revealed Resident #29 had severely impaired cognition with a Brief Interview for Mental Status (BIMS) score of three. Resident #29 was dependent on staff Furthermore, Resident #29 did not have any wounds, but was at risk for pressure ulcers.Review of Resident #29's care plan dated 03/27/25 revealed the resident was at risk for skin breakdown due to impaired mobility, chronic kidney disease and type II diabetes mellitus. Interventions included for staff to apply advanced skin protectants, barriers, cleansers, and moisturizers, assist with bed mobility and to turn and reposition frequently, assist with toileting, preventive skin care as ordered, skin inspections weekly and as needed with findings documented and the provider notified of any abnormal findings, clinical assessments for any deteriorating symptoms or characteristics will be documented, reported to the provider, treated timely, and provider prescribed or recommended nutritional provided each shift and documented. The care plan updated on 05/04/26 revealed Resident #29 had impaired skin integrity related to diabetic foot ulcers to the left heel, and the right fourth and fifth digits. Interventions included to complete wound treatments as ordered, provide supplements as ordered, use heel protector boots as tolerated, assess for pain and treat as indicated, assess and document skin condition, notify the provider of signs of infection, of worsening or no improvement of the wound.Review of Resident #29's physician visit notes revealed Resident #29 was seen by the house physician on 04/23/26 with no new skin areas were noted. Review of Resident #29's weekly skin evaluations from 03/11/26 to 05/03/26 revealed weekly skin evaluations were completed on 03/11/26, 03/18/26, 04/03/26, and 05/03/26.Review of Resident #29's shower sheets dated 04/29/26 and 04/30/26 the resident had a bed bath and there was redness due to the resident picking at a scab on the left shoulder area, the resident had no noted open areas. The shower sheet dated 4/30/26 revealed the resident had bruising but there were not any areas indicated. Review of Resident #29's nursing progress notes revealed on 05/03/26 at 4:01 P.M. the nurse was called into Resident #29's room to check Resident #29's skin due to an open wound on the left heel. The nurse notified the Nurse Practitioner (NP), and an order was received to send the resident to the hospital emergency department for evaluation. Review of Resident #29's ED emergency room encounter document dated 05/03/26 and timed 5:38 P.M. revealed Resident #29's chief complaint was a wound infection of the left heel. Review of the history of present illness note revealed per the Emergency Medical Services (EMS) report the resident had been complaining of left heel pain for approximately two months however the nursing facility found the wound today with no reported injuries or trauma. The resident was alerted to self, was complaining of pain and asking for pain medication. Upon assessment the wound appeared deep with a differential diagnosis of pressure ulcer verses diabetic foot wound. After a workup that included laboratory testing and x-ray to rule out osteomyelitis Resident #29 was discharged back to the nursing home with an open wound and soft tissue swelling to the left heel with oral antibiotics and an order with a start date of 05/04/26 for the left heel to be cleansed with normal saline or wound wash then patted dry, followed by an application of collagen and then wrapped with rolled gauze. Resident #29 had a follow up appointment scheduled for 05/12/26 with wound care. Review of the wound care note dated 05/12/26 and timed 3:49 P.M. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed Resident #29 had an injury of the left heel with unknown etiology. The wound eschar was unable to be removed. An order for the left heel included for the wound to be cleansed with liquid antibacterial soap and water and rinsed well followed by Santyl ointment, nickel thickness applied to the wound bed, covered with saline moistened gauze, an abdominal wound dressing and wrapped with rolled gauze was written with a follow up appointment scheduled in one week. Resident #29 was also ordered Doxycycline 100 milligrams twice a day for 10 days, an increased protein diet (meat, cheese egg, fish, peanut butter, nuts and beans), a multivitamin daily, foam offloading boots, frequent turns and a had a referral sent to vascular surgery. Review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) for May 2026 revealed Resident #29 had wound care treatments completed as ordered, Doxycycline was administered as ordered and the resident was scheduled to see vascular surgery on 05/22/26 at 10:!5 A.M. Further review of the MAR or TAR for May 2026 revealed Resident #29 did not receive an increased protein diet, a daily multivitamin, off-loading boots or frequent turns. Interview on 06/15/26 at 10:23 A.M. with the Director of Nursing (DON) verified that skin evaluations should be completed weekly. Furthermore, the DON verified for Resident #29, there were no weekly skin evaluations completed between 04/03/26 and 05/03/26. Interview on 06/15/26 at 10:49 A.M. with Culinary Manager (CM) #274 verified Resident #29 was on a regular diet, regular texture, and honey/moderately thick consistency for liquids. CM #274 stated if a resident has a diet change nursing needs to enter the dietary order into the electronic medical record (EMR) at which time the dietary department would implement the diet order as ordered. CM #274 verified they do not have an order for Resident #29 to receive increased proteins and further verified the increased protein would be listed on the diet if ordered. Observation of Resident #29's diet card at the time of the interview stated the resident was on a regular diet, regular texture, honey/moderately thick consistency for liquids, there was nothing regarding an increased protein diet.Follow up interview with the DON on 06/16/26 at 11:29 A.M. verified the diet order and the daily multivitamin that was ordered by wound care had not been implemented for Resident #29. Interview on 06/16/26 at 2:46 P.M. with Resident #29 revealed the resident could not recall how the wound on her heel was obtained. Resident #29 denies being turned and repositioned on a regular scheduled basis. 2. Review of the medical record for Resident #12 revealed an admission date of 06/05/25. Diagnoses included bipolar disorder, fibromyalgia, hypertension, type II diabetes mellitus, hemiplegia and hemiparesis following a cerebral infarction affecting the right (dominant) side. Resident #12 had a stage 4 pressure ulcer to the sacral region and a pressure ulcer to the right heal. Review of Resident #12's quarterly MDS assessment dated [DATE] revealed the resident had severely impaired cognitive skills for daily decision making and was rarely or never understood. Furthermore, Resident #12 had a stage three and stage four pressure ulcer and was dependent on staff for rolling left and right. Review of Resident #12's care plan dated 06/06/25 revealed the resident was at risk for further skin breakdown due to current pressure areas, COPD, type II diabetes mellitus, hemiplegia, ADL dependence and use of supplemental oxygen. Interventions included the use of advanced skin protectants, barriers, cleansers, moisturizers, check for incontinence and provide incontinence care as needed, low air mattress on bed, preventative skin care as ordered, reposition frequently, skin inspections weekly and as needed, document and notify the provider of any abnormal findings. The care plan updated 03/27/26 revealed the resident had impaired skin integrity related to pressure ulcers on the right heel and sacrum, and a vascular ulcer on the right shin. Interventions included to provide wound treatments as ordered and to assist with bed mobility to turn and reposition routinely. Review of a physician order dated 10/13/25 revealed Resident #12's skin was to be assessed weekly every night shift on Wednesdays. Review of weekly skin assessments for Resident #12 from 03/09/26 until 06/01/26 revealed skin assessments were completed on 03/09/26, 03/20/26, 04/15/26, 04/30/26, 05/07/26, 05/21/26, 06/01/26. Further review of the skin assessment dated [DATE] revealed Resident #12 had an open blister to the right side of the middle back measuring 5 centimeters (cm) long by 1.5 cm wide. Observation on 06/16/26 at 7:50 A.M. of Resident #12 revealed the resident was (continued on next page)

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	366039	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Point Place	6101 N Summit St Toledo, OH 43611

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observed lying in bed positioned on her back. The resident had a functioning low air loss mattress in place.Observation on 06/16/26 at 9:55 A.M. of Resident #12 revealed the resident was observed lying in bed positioned on her back.Interview on 06/16/26 at 9:56 A.M. with Certified Nursing Assistant (CNA) #346 verified he began his shift on Resident #12's hall at 6:15 A.M When asked when the last time Resident #12 was repositioned, CNA #346 stated not yet today. Furthermore, CNA #345 stated the previous shift would have been the last people who would have turned and repositioned Resident #12.Interview on 06/16/26 at 1:43 P.M. with the DON verified residents should be turned and repositioned every two hours, aides know to do two hours checks. The DON reported that no staff had reported to her that turning and repositioning was not completed or that they needed help to turn and reposition the residents. Review of the facility policy titled Activities of Daily Living, revised 03/19/26 stated each resident will receive the necessary care and services to maintain or improve ADLs, and those that are unable to perform ADLs will receive the necessary services to prevent avoidable decline. Care will be individualized, assessment-driven, person centered support consistent with the residents' needs. Review of the facility policy titled Wound Care Policy, with a revision date of 03/17/26 stated it is the responsibility of every care team member to ensure residents who do not have skin integrity impairments do not develop a new condition affecting the skin and residents with impaired skin integrity are treated timely, and interventions to heal are not exhausted until the skin is healed. Furthermore, residents will have their skin assessed at the time of admission/re-admission and evaluated routinely to ensure the skin is intact. Routine skin monitoring is completed to recognize any early symptoms of the development of a new skin impairment. If a risk factor or new symptom is discovered the care team member will assess the resident's skin, care plan any near care initiative, operationalize care initiative, and monitor and evaluate those care initiatives.This deficiency represents non-compliance investigated under Complaint Number 3038257.

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F 0727 Level of Harm - Potential for minimal harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on review of the daily posted staffing information, review of staff time cards, interview, and policy review, the facility failed to ensure a Registered Nurse (RN) was present for eight consecutive hours in the facility. This had the potential to affect all residents. The facility census was 76. Findings include:Review of the daily posted staffing information dated 06/06/26 revealed one Registered Nurse (RN) was scheduled to work 5.25 hours. A second RN with administrative duties was scheduled to work 7.5 hours. Review of the employee timecard dated 06/06/26 for RN #354 revealed a start time of 6:40 A.M. and an ending time of 12:12 P.M. Review of the handwritten and unsigned employee timecard dated 06/06/26 for the former RN#513 revealed a start time of 1:00 A.M. and an ending time of 2:15 A.M. then another start time of 7:00 P.M. and an ending time of 11:00 P.M. Further review of the timecards revealed no other RNs worked on 06/06/26 and no RN worked for eight consecutive hours. Interview on 06/15/26 at 12:32 P.M., the Administrator verified there was not an RN working in the facility for eight consecutive hours on 06/06/26. Review of the facility policy Staffing, last revised 09/19/24, revealed the facility would utilize the services of an RN for at least eight consecutive hours a day, seven days per week. This deficiency represents noncompliance investigated under Complaint Number 3038257.

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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 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 review of the medical record, review of a facility statement, review of Emergency Medical Services incident run reports, interview, and policy review, the facility failed to ensure accurate and thorough documentation in the medical record. This affected two (#14, #77) of three residents reviewed for medical documentation. The facility census was 76.Findings include:1. Review of the medical record for Resident #14 revealed an admission date of [DATE]. Diagnoses included dementia, anxiety, hypertension, and spinal stenosis. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. The resident used a walker for ambulation with staff supervision. The resident required substantial/maximal assistance for toileting and partial/moderate supervision for transfers. The resident wore a wander/elopement alarm daily. Review of the elopement risk assessment completed [DATE] and [DATE] revealed the resident was at risk for elopement. Review of the care plan dated [DATE] revealed the resident was at risk for elopement due to confusion and attempts to leave the facility unattended. Interventions included for staff to assess for unmet needs, assess elopement risk quarterly and as needed, place resident profile in elopement book, redirect the resident when wandering or exit seeking, and wander guard to the left ankle, check function and placement daily. Review of an undated and unsigned statement from the facility revealed on [DATE] Resident #14 was observed walking up the driveway toward the main driveway by therapy staff who notified Licensed Practical Nurse (LPN) #330. LPN #330 notified the Director of Nursing (DON) and went outside and brought the resident into the facility. Resident #14 reported she had returned from a leave of absence with a friend and wanted to smoke a cigarette before she came back into the facility. LPN #330 and the DON noted the wander guard alarm was working properly when they brought the resident back into the facility. The DON noticed Resident #14's friend sitting in her vehicle in the first row of the parking lot. The DON checked the sign out book and noted Resident #14's friend had signed the resident out for a leave of absence. Review of electronic communication (email) dated [DATE] revealed Social Worker #254 notified the resident's guardian about the resident not being escorted back inside the building by her friend after a leave of absence. Review of the nursing progress notes dated [DATE] through [DATE] revealed no documentation about the resident being found unattended in the parking lot. Further review of the medical record revealed no documentation the resident's guardian was notified. Interview on [DATE] at 10:39 A.M., LPN #330 at first was unable to recall finding Resident #14 outside unattended. LPN #330 then revealed she was walking through the therapy gym and noticed the resident outside and she notified the DON and went out and got the resident. LPN #330 revealed the resident had gone out to smoke and was not supposed to. LPN #330 stated the incident that occurred two to three weeks ago. LPN #330 revealed she thought the resident's sister was somewhere in the parking lot. Interview on [DATE] at 10:45 A.M., the DON revealed the resident was allowed to leave with supervision. The DON revealed the incident occurred about two to three weeks ago. The DON verified the incident was not documented in the medical record because the resident was within eyesight. Interview on [DATE] at 10:52 A.M., the Administrator revealed the resident would go on leave of absence with her sister and a friend. The Administrator revealed she was not aware of the resident getting out of the building. The Administrator then stated the resident was outside in the parking lot but was not unsupervised because her friend was parked in the parking lot. The Administrator verified there was no documentation of the incident in the medical record. The Administrator stated there was a conversation with the resident's guardian but verified it was not documented in the medical record. The Administrator revealed maybe the notification was in an email.Interview on [DATE] at 2:07 P.M., Regional Registered Nurse (RRN) #526 verified the staff should have created a risk report regarding the incident. RRN #526 stated while there was no documentation in the medical record, the incident (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not dismissed, and staff had followed up with the guardian regarding the incident. RRN #526 was informed during surveyor interviews, several staff had varying accounts of how and when the incident occurred. RRN #526 revealed the team put their heads together and were able to recall the incident had happened on [DATE]. Review of facility policy Incidents, Accidents, and Supervision, dated [DATE], revealed an incident was an occurrence or situation not consistent with the routine care of a resident or with any routine operation. This could involve a visitor, vendor, or Care Team Member. The purpose of incident reporting includes assuring appropriate and immediate interventions were implemented and corrective actions were taken to prevent reoccurrences and improve the management of resident care. A resident would be assessed for elopement risk and interventions would be documented. A timeline, search efforts and notification would also be recorded. Care plans would be updated, and environmental/system changes would also be documented. 2. Review of the closed medical record for Resident #77 revealed an admission date of [DATE] and a discharge date of [DATE] when the resident expired in the facility. Diagnoses included Huntington's disease, dysphagia, anxiety, and gastrostomy status. Review of the quarterly MDS assessment dated [DATE] revealed the resident had severe cognitive impairment. The resident was dependent on staff for all activities of daily living.Review of the care plan dated [DATE] and last revised on [DATE] revealed the resident had chosen a full code status (cardiopulmonary resuscitation (CPR) would be initiated in the event of a cardiac or respiratory event) with a goal to honor the resident's decisions regarding healthcare choices. Only one intervention was in place stating for staff to activate the residents' advanced directive as indicated. Review of the physician orders dated [DATE] revealed the resident had elected a full code status. Review of a vital sign report dated [DATE] at 7:20 P.M. for Resident #77 revealed the resident's blood pressure was 113 systolic over 71 diastolic, with a pulse of 58 beats per minute. The resident's oxygen saturation level was 96 percent on room air and the resident's respiratory rate was 16 breaths per minute. Review of a vital sign audit report dated [DATE] revealed the vital signs documented on [DATE] at 7:20 P.M. were not entered into the electronic medical record until [DATE] at 7:50 A.M.Review of a late entry nurses note dated [DATE] at 11:30 A.M. (documented on [DATE] at 7:55 A.M.) revealed the funeral home picked up the resident's body at 11:30 P.M. Review of a late entry nurse's note dated [DATE] at 11:40 A.M. (documented on [DATE] at 7:54 A.M.) revealed LPN #200 was notified by a nursing assistant that the resident was unresponsive. LPN #200 checked the residents' vital signs and they were absent. The resident was a full code and CPR was initiated. Other staff nurse notified and called 911. The crash cart was present, and the AED (automated external defibrillator) was applied. Emergency Medical Services (EMS) arrived and took over life sustaining measures. The resident's pronounced time of death was 8:50 P.M. The physician, family, and funeral home were notified. Further review of the nurse's notes dated [DATE] and [DATE] revealed no documentation the resident was not provided ventilations during CPR. Review of a late entry SBAR summary for providers progress note dated [DATE] at 11:41 A.M. (documented on [DATE] at 7:48 A.M.) revealed the resident had a respiratory arrest and was unresponsive. At the time of the evaluation, no vital signs had been documented.Review of the EMS incident run reports dated [DATE] revealed the nursing home staff called 911 at 8:06 P.M. EMS arrived on scene at 8:16 P.M. and at Resident #77's bedside at 8:18 P.M. EMS continued life saving measures until the physician later directed EMS to cease efforts. The resident was pronounced expired at 8:57 P.M. Interview on [DATE] at 12:52 P.M., LPN #200 verified she had not documented the Resident #77's code in the medical record until the following day. LPN #200 also verified the incident events were also documented at the incorrect times. Interview on [DATE] at 10:49 A.M., the DON verified LPN #200 had inaccurately documented the time of Resident #77's code and the subsequent events. Review of the facility policy Documentation in the Medical Record, dated [DATE], revealed each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Licensed (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff and interdisciplinary team members would document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy.This deficiency represents noncompliance investigated under Complaint Number 3038257.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and policy review, the facility failed to maintain required infection control standards during a dressing change. This affected one (#49) of three residents reviewed for wounds. Additionally, the facility failed to ensure bedpans and basins were properly stored in a sanitary manner. This affected one (#34) of three residents reviewed for activities of daily living. The facility identified eight residents utilizing bedpans. The facility census was 76.Findings include:Review of Resident #49's medical record revealed an admission date of 12/14/23. Diagnoses included chronic obstructive pulmonary disease, type two diabetes mellitus, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, muscle weakness, and dysphagia. Review of Resident #49's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #49 had moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of 12. Furthermore, Resident #49 was at risk for developing pressure ulcers and required set up or clean up help with bed to chair and chair to bed transfers. Review of Resident #49's care plan dated 04/17/26 revealed Resident #49 was at risk for skin breakdown related to incontinence and type II diabetes mellitus. Interventions included pressure reducing/redistributing cushion to chair and bed, preventive skin care as ordered, skin inspections weekly and as needed, document skin inspections and report any abnormalities to the provider and to follow the treatment plan. Resident #49 was also care planned for being at risk for complications and symptoms of hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar). Interventions included to observe for signs or symptoms of hypo/hyperglycemia such as poor wound healing, and to perform skin inspections weekly and as needed, paying particular attention to the feet. Review of a nursing progress note dated 06/09/26 revealed Resident #49 had an abrasion to the right great toe. The provider was notified and order was received to cleanse the right great toe with soap and water, then cover with calcium alginate and a dry dressing daily and as needed until healed. Observation on 06/16/26 at 8:04 A.M. of wound care completed by Licensed Practical Nurse (LPN) #308 for Resident #49 revealed Resident #49 had an abrasion to his right great toe. LPN #308 washed her hands prior to beginning the dressing change. LPN #308 donned gloves and removed the previous dressing. LPN #308 discarded the old dressing and with the same gloves, LPN #308 washed the wound with soap and water per the physician's orders. After washing and rinsing the wound with soap and water, LPN #308 discarded her gloves, performed hand hygiene, and donned a new pair of gloves to apply the new dressing. Interview on 06/16/26 at 8:15 A.M. with LPN #308 verified she used the same gloves to take off the old dressing and to wash and rinse the wound. Review of the facility validation checklist for wound care with a copyright date of 2022 revealed the nurse should remove a dressing and place it in an appropriate receptacle, perform hand hygiene and don clean gloves, and then cleanse the wound thoroughly with the prescribed cleansing agent. 2. Review of the medical record for Resident #34 revealed an admission date of 02/25/26. Diagnoses included chronic respiratory failure, type two diabetes mellitus, hypertension, and atrial fibrillation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the significant change MDS assessment dated [DATE] revealed the resident had intact cognition. The resident was always incontinent of bowel and bladder. The resident was dependent on staff for toileting. Review of the physician orders dated 04/27/26 revealed the resident had orders for enhanced barrier precautions due to a multi-drug resistant organism. Observation on 06/16/26 at 2:50 P.M. revealed a bath basin and a bed pan were in direct contact with the floor underneath the sink in the resident's bathroom. Interview on 06/16/26 at 2:50 P.M., Resident #34 revealed she was incontinent of urine and would use the bedpan if she knew timely she needed toileting. Interview on 06/16/26 at 2:52 P.M., Registered Nurse (RN) #265 verified the bath basin and bedpan had been placed directly on the floor in the bathroom. Interview on 06/16/26 at 2:55 P.M., the Director of Nursing (DON) revealed bed pans should be stored in a bag if reused. Follow-up interview with the DON revealed that the facility had no specific infection control policy regarding the reuse and storage of bed pans. Review of the facility policy Safe and Homelike Environment, dated 01/01/26, revealed the facility would prevent the spread of disease-causing organisms by keeping resident/patient care equipment clean and properly stored. This deficiency represents noncompliance investigated under Complaint Number 3038257.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the crash cart checklist logs, staff interview, and policy review, the facility failed to ensure the two facility crash carts were properly maintained. This had the potential to affect all residents. The facility census was 76. Findings include:Review of the facility crash cart checklist for the 200/300 hall dated [DATE] through [DATE] revealed facility staff checked the contents of the cart on the first of the month. If the cart had not been used then the intact lock tag number was verified and signed off daily as intact by staff. The contents of the cart were last verified on [DATE] and signed off daily through [DATE]. There were no directions on the crash cart checklist alerting staff to check for expired items. Review of the facility crash cart checklist for hall 100 dated [DATE] through [DATE] revealed the facility staff checked the contents of the cart on the [DATE]. No lock number was noted on the checklist from [DATE] through [DATE]. On [DATE] the crash cart lock tag number was identified, and the content check was noted as complete. There were no directions on the crash cart checklist alerting staff to check for expired items. Observation on [DATE] beginning at 9:27 A.M. with Licensed Practical Nurse (LPN) #330 of the crash cart located on hall 100 revealed the bag valve mask (BVM) used during cardiopulmonary resuscitation had expired on [DATE]. Interview on [DATE] at 9:28 A.M., LPN #330 verified the BVM expired on [DATE]. LPN #330 revealed staff were required to check the contents of the crash cart monthly and after each use. LPN #330 revealed there were no directions on the crash cart logs for staff to check the items in the crash cart for expiration dates. Observation on [DATE] at 9:30 A.M. of the crash cart located on the 200/300 hall revealed there were two Yankauer suction tip catheters (oral suction tool) with expiration dates of [DATE]. Additionally, there were three intravenous (IV) start kits with expiration dates of [DATE], [DATE], and [DATE], suction tubing with an expiration date of [DATE], and a nebulizer mask with an expiration date of [DATE].Interview on [DATE] at 9:33 A.M., LPN #330 verified the expiration dates of the IV start kits, Yankauer catheters, suction tubing, and nebulizer mask. Interview on [DATE] at 2:31 P.M., the Administrator revealed it was her expectation that the central supply staff would check medical equipment monthly for expiration dates. The Administrator revealed the crash carts should be audited monthly. The Administrator revealed she was unaware if there was a formal process for checking the expiration dates of the supplies in the crash carts. The Administrator revealed she was unaware if staff had been educated on checking for expiration dates. Interview on [DATE] at 7:35 A.M., the Director of Nursing (DON) verified the facility had no policy on maintaining the crash carts or checking for expired medical supplies. Review of the facility policy Safe and Homelike Environment, dated [DATE] revealed the facility would provide a safe, clean, comfortable, and homelike environment ensuring the delivery of care and services in a manner that minimized safety risks and promoted well-being. This deficiency represents noncompliance investigated under Complaint Number 3038257.