STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366041	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Addison Heights Health and Rehabilitation Center	3600 Butz Rd Maumee, OH 43537

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on staff interview, and review of facility staffing documentation, the facility failed to ensure a Registered Nurse was scheduled eight consecutive hours when the facility exceeded a census of 60 residents. This affected all 60 residents residing in the facility. Review of facility staffing documentation and related schedules between 09/01/25 and 09/07/25. Facility census was 61 current residents on 09/04/25, 09/05/25, 09/06/25. The facility Director of Nursing was listed as the only Registered Nurse in the facility. On 09/11/25 at 1:07 P.M. interview with Scheduling Coordinator (SC) #466 during a review of facility schedules between 09/01/25 and 09/07/25 verified no additional Registered Nurse was scheduled in the facility on 09/04/25, 09/05/25, 09/06/25. SC #466 also confirmed the facility exceeded a resident census of 60 on each of the three days. This deficiency represents non-compliance investigated under Complaint Number 2608577.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, review of manufactures guidelines, review of pharmacy policy, and review of facility policy, the facility failed to store medications that require refrigeration. This affected Resident #13. The facility failed to ensure the freezer, located inside of the medication-storage refrigerator, was properly maintained. This affected eight residents (#10, #13, #33, #34, #37, #42, #60, and #68) that were identified by the facility as utilizing medications that required refrigeration. The facility also failed to ensure the medication-storage refrigerator maintained the correct temperature parameters to safely store medications that require refrigeration. This affected eight residents (#10, #13, #33, #34, #37, #42, #60, and #68) that were identified by the facility as utilizing medications that required refrigeration. The facility also failed to ensure that multi-use vials of medication were labeled properly when opened. This had the potential to affect all residents in the facility. The facility also failed to ensure supplies were discarded upon expiration. This had the potential to affect all residents in the facility. The facility census was 60. Findings Include: 1.) Review of the medical record for Resident #13 revealed an admission date of [DATE] with diagnoses of facial weakness, obesity, Vitamin D deficiency, major depressive disorder, chronic pain syndrome, allergic rhinitis, unspecified asthma, urge incontinence, gastro-esophageal reflux disease (GERD), type two diabetes mellitus (DM2), chronic kidney disease (CKD), lumbar disc degeneration, generalized muscle weakness, unsteadiness on feet, lack of coordination, osteoarthritis, and morbid obesity. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15, indicating Resident #13 was cognitively intact. Further review of the MDS assessment revealed Resident #12 required substantial or maximal assistance with all functional abilities. Observation on [DATE] at 3:38 P.M. of the medication cart for the 200-hall revealed a four milligram (mg)/three milliliter (mL) syringe of Ozempic (a weekly injectable medication that helps lower blood sugar by helping the pancreas make more insulin), approximately one-quarter used, for Resident #13. Further observation of the Ozempic syringe revealed the Ozempic was not labeled with a date when it was opened and when it expired. Interview on [DATE] at 3:38 P.M. with Licensed Practical Nurse (LPN) # 415 verified the four milligram (mg)/three milliliter (mL) syringe of Ozempic, was approximately one-quarter used, and in the medication cart for the 200-hall without being labeled with a date of when it was opened and when it expired. Further interview with LPN #415 revealed all Review of the facility policy titled, Medication Storage, dated [DATE], revealed Ozempic can be stored at room temperature for 56 days after opening. 2.) Observation on [DATE] at 7:09 A.M. of the medication storage room, located at the intersection of the 100 and 200 halls, revealed a medication storage refrigerator which contained a small freezer. Further observation of the freezer portion revealed it was completely encased in ice. Interview on [DATE] at 7:15 A.M. with LPN #417 verified the freezer, located inside of the medication storage refrigerator, was completely encased in ice. Review of the facility policy titled, Storage of Medications, dated [DATE], revealed the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. 3.) Observation on [DATE] at 7:09 A.M. of the medication storage refrigerator contained in the medication storage room, located at the intersection of the 100 and 200 halls, revealed the refrigerator temperature was 52 degrees Fahrenheit (F). Interview on [DATE] at 7:15 A.M. with LPN #417 verified the refrigerator temperature was 52 F.Review of the facility policy titled, Medication Storage, dated [DATE], revealed all medication that required refrigeration, required a temperature range of 36 F to 46 F. 4.) Observation on [DATE] at 7:09 A.M. of the medication storage refrigerator contained in the medication storage room, located at the intersection of the 100 and 200 halls, revealed two one mL vials of Tuberculin Purified Protein Derivative (PPD), both with lot (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	number 4CA02C1, and both with a manufacturer's expiration date of 07/28. Both bottles of PPD contained instructions printed on the bottle to discard product 30 days after opening. Neither of the opened bottles of PPD not labeled with the date they were opened. Interview on [DATE] at 7:15 A.M. with LPN #415 verified the medication storage refrigerator contained in the medication storage room, located at the intersection of the 100 and 200 halls, contained two opened one mL vials of PPD, and both were not labeled with the date they were opened. Review of the facility policy titled, Medication Storage, dated [DATE], revealed PPD expires 30-days after opening. 5.) Observation on [DATE] at 7:25 A.M. of the medication storage room located in the memory care (MC) unit revealed a 100-count box of 1mL tuberculin safety syringes with needle with a manufactures expiration date of [DATE], a 100-count box of one-inch 21 gauge (g) safety hypodermic needles with a manufacturers expiration date of [DATE], a 100-count box of 1mL tuberculin safety syringes with needle with a manufactures expiration date of [DATE], and a 100-count box of 1mL tuberculin safety syringes with needle with a manufactures expiration date of [DATE]. Interview on [DATE] at 7:35 A.M. with the Director of Nursing (DON) verified the medication storage room located in the MC unit contained a 100-count box of 1mL tuberculin safety syringes with needle with a manufactures expiration date of [DATE], a 100-count box of one-inch 21 gauge (g) safety hypodermic needles with a manufacturers expiration date of [DATE], a 100-count box of 1mL tuberculin safety syringes with needle with a manufactures expiration date of [DATE], and a 100-count box of 1mL tuberculin safety syringes with needle with a manufactures expiration date of [DATE]. Review of the facility policy titled, Storage of Medications, dated [DATE], revealed the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, staff interviews, resident interviews, and schedule reviews the facility failed to ensure adequate kitchen staff were available to provide timely meal service. This affected all residents. The facility census was 60.Observation of the kitchen staff on 09/08/25 at 8:00 A.M. revealed only Dietary Manager #504 was working in the kitchen and was preparing the breakfast meal.Review of the dietary staffing schedule dated 09/08/25 revealed one cook was scheduled from 6:00 A.M. to 2:00 P.M., and a dietary aide from 7:00 A.M. to 3:00 P.M. and a second aide from 10:00 A.M. to 8:00 P.M. There were two open shifts from 4:00 P.M. to 7:00 P.M. and 7:00 A.M. to 10:00 A.M.Interview with Dietary Manager #504 on 09/08/25 at 8:00 A.M. revealed two additional staff were scheduled, but failed to come into work.Observation at 12:45 P.M. revealed Resident #26 was in the main lobby asking staff where lunch was because she was hungry.Observation on 09/08/25 revealed lunch service was not provided until 1:00 P.M. to 1:42 P.M. Interview with Residents #22, #26, and #30 revealed lunch was very late.Interview with the Dietary Manager on 09/08/25 at 2:22 P.M. revealed Medical Records Coordinator #465 was transferred into the kitchen to assist with meal service. Interview with the Administrator stated the facility contingency plan was to have other qualified staff work in the kitchen if that department was understaffed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and policy review the facility failed to dispose of expired foods and store foods properly. This had the ability to affect all residents. The facility census was 60.Kitchen observation on 09/08/25 at 7:57 A.M. revealed several foods were found expired in the walk in refrigerator. A plastic container of pears was dated 08/30/25 and marked to be used by 09/03/25. A large plastic container of jelly was dated 08/04/25 and use by date was 09/04/25. A plastic container was dated 09/07/25 and use by date was 09/07/25. Further observation revealed two five pound rolls of ground beef were sitting on a tray and had a red liquid substance on the tray. The meat failed to be labeled with dates.Observation of the walk-in freezer on 09/08/25 at 8:05 A.M. revealed a plastic bag of frozen chicken patties were left open to air. Observation of the dry storage area on 09/08/25 at 8:08 A.M. revealed a plastic bin sitting on the floor with bread crumbs inside. The lid failed to be attached properly and was allowing the crumbs to be open to air.Interview with Dietary Manager #504 on 09/08/25 at 8:10 A.M. verified the above mentioned foods failed to be stored properly per facility policy.Review of the facility policy titled Food Storage undated, revealed containers for bulk items (flour, sugar, etc.) are leak-proof, non-absorbent, sanitary, National Sanitation Foundation (NSF) approved, and have tight-fitting lids. Containers are to be dated and labeled with the contents. All food not in original containers will be labeled, dated, and stored in NSF approved containers.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on record review and staff interview, the facility failed to implement and monitor an effective water management program to minimize the risk for Legionella growth in the facilities building. This had the potential to affect all residents. The facility census was 60. Review of the facilities policy titled Legionella Infection Control Protocol, undated, revealed the facility will flush toilets and run sinks in resident's rooms daily to flush any standing water. The facilities protocol does not address flushing water in any other areas or a way to track and monitor areas that have been flushed. Interview on 09/09/25 at 12:11 P.M. with Director of Maintenance #458 revealed that maintenance runs water in all rooms and that water is tested with an instant read tester for Legionella randomly and a sample is sent out yearly for testing. Maintenance Director did not know if tracking sheets for the flushes or the yearly test results were available due to only working there since June. Interview on 09/09/25 at 3:13 P.M. with Director of Maintenance #458 revealed a document titled Monthly Flushing and Faucet Inspection with all rooms checked off for the months of June 2025, July 2025, and August 2025. None of the months prior to June 2025 had any checks marked. Furthermore, Director of Maintenance stated he couldn't find any verification of yearly water testing or any further information about the Legionella control measures being taken at the facility. Review of The Centers for Disease Control and Prevention (CDC) Plan for Legionella control titled Developing a Water Management Program to Reduce Legionella growth & Spread in Buildings, dated 06/24/25, revealed there are seven steps to an effective water management program:1. Establish a water management program team.2. Describe the building water systems using text and flow diagrams.3. Identify areas where Legionella could grow and spread.4. Decide where control measures should be applied and how to monitor them.5. Establish ways to intervene when control limits are not met.6. Make sure the program is running as designed and is effective.7. Document and communicate all the activities.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, review of medical record, and review of facility policy, the facility failed to ensure there was an adequate supply of linens to meet resident needs. This affected Resident #10. The facility also failed to ensure shower chairs were in good repair and functional in the 100-hall shower room. This affected 28 residents (#5, #6, #8, #10, #13, #17, #18, #20, #24, #25, #26, #28, #32, #33, #34, #38, #39, #41, #43, #44, #45, #46, #49, #52, #56, #58, and #63) identified by the facility as using this shower room and residing in the 100 and 200 halls. The facility failed to ensure a clean and homelike environment in resident rooms. This affected two residents (#10 and #17). The facility failed to ensure resident window shades were in functional working order. This affected two residents (#22 and #51). The facility failed to ensure baseboard heater covers were in place and intact in resident rooms. This affected Resident #20. The facility failed to ensure the walls in a resident room were in good repair. This affected Resident #23. The facility census was 60. 1.) Observation on 09/15/25 at 9:20 A.M. revealed Resident #10 required a linen change. Continued observation at 9:23 A.M. revealed there was no linen in Resident #10's room and at this time, Licensed Practical Nurse (LPN) #403 pressed the call light to request linens. Observation at 9:27 A.M. of a conversation between LPN #403 and an unidentified Certified Nursing Assistant (CNA) revealed there is minimal linen in the linen room and there are no flat sheets. Interview on 09/15/25 at 9:35 A.M. with LPN #403 revealed she was unable to provide Resident #10 with a clean flat sheet or blanket at this time as none are available. Observation on 09/15/25 at 9:35 A.M. of the 300-hall linen room with CNA #473 revealed there are two flat sheets, three fitted sheets, and five bath towels on the 300-hall. Interview at the time of observation with CNA #473 verified these findings. Observation on 09/15/25 at 9:38 A.M. of the linen room for the 100 and 200 halls with CNA #499 revealed five fitted sheets, no flat sheets, and approximately 10 bath towels. Interview at the time of observation with CNA #499 verified these findings. Interview on 09/15/25 at 9:45 A.M. with LPN #403 revealed when she gets here in the morning, the facility often does not have an adequate supply of linen to perform incontinence care for residents or change residents' bedding, so she is forced to delay these tasks until linens become available. Review of the facility policy titled, “Homelike Environment”, dated February 2021, revealed the facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include clean bed and bath linens that are in good condition. 2.) Observation on 09/11/25 at 1:24 P.M. of the shower room located on the 100-hall with CNA #482 revealed two wheeled shower chairs, both of which are broken. The first broken wheeled shower chair, was constructed of white plastic with blue fabric, had broken wheels. The second broken wheeled shower chair, was constructed of white plastic with pink fabric, had a broken handle. Interview at the time of observation with CNA #482 verified these findings. Concurrent interview with CNA #482 revealed the broken wheeled shower chair with blue fabric and the broken wheels will not turn right and the broken wheeled shower chair with pink and the broken handle does not turn when a resident is in it due to the condition of the handle. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.) Observation on 09/09/25 at 12:43 P.M. of Resident #17's room revealed cobwebs in the right corner of her window and paint on the wall by Resident #17's bed with multiple chips exposing the drywall. Interview at the time of observation with Resident #17 revealed she is not pleased with the environmental conditions or cleanliness of her room and stated she has addressed the concerns with the facility administration previously. Interview on 09/09/25 at 12:48 P.M. with LPN #415 verified these findings. Observation on 09/15/25 beginning at 9:20 A.M. of Resident #10's room revealed an empty chip bag on the floor, crumbs on the floor, unidentified stains, and food and crumbs in his bed. Interview at the time of observation with Resident #10 revealed the cleanliness of his room is not maintained to his preference. Interview on 09/15/25 at 9:40 A.M. with LPN #403 revealed Resident #10 verified the findings in Resident #10's room. 4.) Observation of room [ROOM NUMBER] on 09/08/25 at 10:10 A.M. revealed the window blinds were bent which resulted in a lack of privacy from the outside. There was one set of blinds which were to cover the entire window and there were no curtains. An area of approximately 8 inches long by 12 inches wide of the slates on the left side of the blinds were bent which resulted in the window being exposed. Multiple other slates were bent and failed to provide privacy. Interview with room [ROOM NUMBER]'s residents (#22, #51) on 09/10/25 12:04 P.M. revealed the residents stated the sun would come in through the blinds when they were trying to sleep. The residents also stated the broken and bent blinds prevent privacy from the outside and they wished the blinds were in working order. 5.) Observation on 09/09/25 at 10:50 A.M. noted an electric base board heater next to Resident #20 bed without a cover leaving exposed rusty and bent metal heater fins. Behind Resident #20 bed headboard discovered wallpaper shredded and pealing from wall. Drywall was exposed and crumbling away from the wall. The wooden bathroom door had several holes penetrating the door. 6.) Observation during facility tour on 09/09/25 between 10:00 A.M. and 11:35 A.M. revealed multiple drywall repair areas in Resident #23's room. Next to the door in Resident #23's room was a large, approximately two feet by two feet area that had been patched with drywall plaster and multiple areas of varying sizes of drywall repair spots throughout entire room. The ceiling in Resident #23's room had a drywall seam approximately 18 to24 inches long that had been repaired and some of the repair tape used was hanging down a few inches from the ceiling. Interview on 09/09/25 at 11:05 A.M. with Resident #23 revealed the repairs in his room were started about two or three months ago and have not yet been completed. Interview with Director of Nursing (DON) on 09/11/25 at 9:51 A.M. confirmed the drywall repair spots and hanging repair tape from ceiling in resident #23's room. Review of the facility policy titled, “Homelike Environment”, dated February 2021, revealed residents are provided with a safe, clean, comfortable and homelike environment. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include clean, sanitary, and orderly (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	environment. This deficiency represents non-compliance investigated under Complaint Number 2608577 and Complaint Number 2593504.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, review of medical record, and review of facility policy, the facility failed to provide care and services in the area of personal hygiene. This affected four residents (#8, #20, #31, and #44) of five residents reviewed for activities of daily living. The facility census was 60.1. Review of the medical record for Resident #31 revealed an admission date of 06/27/25 with diagnoses of thyroid disorder, cerebrovascular accident (CVA), non-Alzheimer ' s dementia, and anxiety disorder. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed moderate cognitive impairment and a requirement of substantial assistance with showering or bathing. Observation on 09/09/25 at 9:21 A.M. revealed Resident #31 sitting in a chair in the common area on the memory care unit with greasy unkept hair and approximately three quarter to one inch hair cluster growth on chin. Interview on 09/09/25 at 12:22 P.M. with Unit Manager #463 confirmed Resident #31 had unkept greasy hair and hair growth on chin. Interview on 09/10/25 at 6:22 with Certified Nursing Assistant (CNA) # 485 confirmed Resident #31 had unkept greasy hair and hair growth on chin. Review of shower schedule sheet, undated, revealed Resident #31 is scheduled for showers on every Tuesday and every Friday. Review of shower sheets for Resident #31 for the last three months revealed Resident #31 only had shower sheets filled out on 07/11/25, 07/23/25, 07/25/25, and 08/22/25. Review of report titled Follow Up Question Report dated 09/09/25, which electronically tracks tasks done for residents, revealed for the month of August 2025 Resident #31 had showers on 08/01/25, 08/06/25, 08/15/25, and 08/20/25. Partial showers were noted on 08/08/25, 08/27/25, and 08/29/25. Furthermore, a Resident shower refusal was noted on 08/22/25. 2.) Review of the medical record for Resident #8 revealed an admission date of 07/02/58 with diagnoses of acute cystitis, cerebral infarction, heartburn, anorexia, personal history of transient ischemic attack (TIA), nicotine dependence, hypomagnesemia, other specified health status, major depressive disorder, adult failure to thrive, altered mental status (AMS), Alzheimer ' s disease, other acquired deformity of head, and unspecified protein-calorie malnutrition. Review of the admission Minimum Data Set (MDS) assessment for Resident #8 revealed a Brief Interview of Mental Status (BIMS) score of 06, indicating Resident #8 was severely cognitively impaired. Further review of the MDS assessment for Resident #8 revealed she required substantial or maximal assistance with all Activities of Daily Living (ADLs). Observation on 09/15/25 at 10:18 A.M. of Resident #8 revealed a large section of matted hair (a condition where hair strands become tangled and intertwined, forming tight clusters that are difficult that are difficult to separate) on the right rear of Resident #8 ' s head. Interview at the time of observation with Resident #8 revealed she did not like her matted hair. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 09/15/25 at 10:22 A.M. with Licensed Practical Nurse (LPN) #415 verified Resident #8 had a large section of matted hair on the right rear of Resident #8 head. Review of the facility shower schedule revealed Resident #8 was scheduled to have showers every Tuesday and Thursday on day shift and as requested. Review of the facility shower documentation for July 2025 revealed Resident #8 was scheduled to receive showers on 07/01/25, 07/03/25, 07/08/25, 07/10/25, 07/15/25, 07/17/25, 07/22/25, 07/24/25, 07/29/25, and 07/31/25, totaling 10 opportunities for showers. Resident #8 did not receive a shower on 07/15/25, with no documentation of resident refusal. Review of the facility shower documentation for August 2025 revealed Resident #8 was scheduled to receive showers on 08/05/25, 08/07/25, 08/12/25, 08/14/25, 08/19/25, 08/21/25, 08/26/25, and 08/28/25, totaling eight opportunities for showers. Resident #8 did not receive a shower on 08/07/25 and 08/12/25, with no documentation of resident refusal. Interview on 09/15/25 at 2:24 P.M. with the Director of Nursing (DON) verified Resident #8 did not receive showers on 07/15/25, 08/07/25, and 08/12/25 as ordered. 3. Resident #20 admitted to the facility on [DATE] with the diagnosis including, chronic obstructive pulmonary disease, atrial fibrillation, major depression, heart failure, chronic kidney disease, anemia, anxiety disorder, hypertension, and type 2 diabetes mellitus. According to the most current minimum data set assessment dated [DATE] Resident #20 was assessed with intact cognition, no recorded behaviors, dependent on staff for the completion of activities of daily living, incontinent of bowel and bladder, and received a diuretic medication. On 01/10/24 a nursing plan of care was developed to address Resident #20 functional abilities impaired, self care and mobility deficit. Interventions included the following; Assist with bed mobility needs. Assist with lower body dressing. Assist with personal hygiene. Assist with toileting needs and incontinence care. Assist with transfer needs utilizing a mechanical lift. Provide assistance with bath and shower. Observation on 09/08/25 at 11:32 A.M. noted Resident #20 in bed wearing covered with a top sheet and wearing an incontinence brief. Resident hair was observed to be long and unkept. The resident also had a long beard which lacked grooming. Interview with Resident #20 at the time stated he had not been offered a haircut or beard grooming for an undetermined time. At 1:10 P.M. and 2:45 P.M. Resident #20 was observed to remain in bed without clothing applied. Observation on 09/09/25 at 10:50 A.M. noted Resident #20 to remain in bed with a sheet covering him and wearing an incontinence brief. Resident #20 stated he was waiting for staff to provide him a bed bath. In addition Resident #20 stated it had been one year since he was provided a haircut and beard grooming. On 09/09/25 at 9:40 A.M. interview with the Director of Nursing revealed no documentation could be provided indicating when Resident #20 last received a haircut. 4. Resident #44 Resident #44 admitted the facility on 01/23/23 with the diagnosis including, congestive heart failure, benign prostatic hyperplasia, chronic obstructive pulmonary disease, epidural (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hemorrhage, bipolar disorder, hypertension, anemia, vascular myelopathies, and fracture of fourth lumbar vertebra. According to the most current minimum data set assessment dated [DATE] Resident #44 was assessed with intact cognition, no resistive behaviors, range of motion impairment to the bilateral upper extremities, utilized a walker or wheelchair for mobility, independent with transferring, required substantial to maximal assistance with activities of daily living, sustained two or more falls since admission. On 04/10/25 a nursing plan of care was developed to address Resident #44 functional abilities impaired self-care and mobility deficit. Interventions included the following; Assist with bed mobility needs. Assist with upper and lower body dressing. Assist with personal hygiene. Assist with putting on and taking off footwear. Review of Resident #44 Activity of Daily Living (ADL) task noted showers scheduled for Mondays and Thursdays. Review of shower sheets and ADL bathing report from 08/09/25 to 09/08/25 documented showers provided on 08/11/25, 08/18/25, 08/25/25, and 08/28/25. This resulted in four of nine scheduled shower opportunities being provided. On 09/08/25 at 12:52 P.M. observation noted Resident #44 seated on his bedside in his room. Resident #44 stated he was unsure who his assigned Certified Nurse Assistant was for the day. Resident #44 was observed with heavy beard growth and greasy hair and stated he was supposed to receive a shower on Monday and Thursday, and often does not get his showers as scheduled. Resident #44 stated the wound specialist left dressings off his legs due to scheduled shower today. On 09/08/2025 at 2:52 PM interview with Certified Nurse Aide (CNA) #481 discovered to be assigned to Resident #44 care between 7:00 A.M. and 3:00 P.M. CNA #481 stated Resident #44 was scheduled for a Tuesday/Friday shower and one was not provided today. Review of activity of daily living (ADL) task documentation with CNA #481 verified Resident #44 was to receive a shower on Monday and Thursday. Further review of ADL task lacked documentation indicating showers were provided as scheduled. On 09/11/25 at 10:45 A.M. interview with the Director of Nursing verified all showers were not provided as scheduled. Review of facility Activities of Daily Living (ADL) policy revised April 2025 stated appropriate care and services are provided for residents who are unable to carry out ADL's independently, with the consent of the resident, and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care). The residents responses to interventions are monitored, evaluated, and revised as appropriate. This deficiency represents non-compliance investigated under Complaint Number 2593504 and Complaint Number 2608577.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and facility pest control documentation, the facility failed to ensure effective insect control was implemented. This affected 10 of 16 residents (#10, #17, #18, #20, #38, #44, #23, #45, #22, #51) reviewed for physical environmental conditions in a facility census of 60. 1.) Observation of Resident #38 on 09/09/25 at 10:36 A.M. revealed the resident was in bed with multiple black flying insects in room and landing on various surfaces. 2.) Observation of Resident #20 on 09/09/25 at 10:50 A.M. revealed black flying insects were observed in the room, landing on resident and bedside beverages sitting on the over bed table. Resident #20 stated insects were visible for an undescribed time and at times landed on food. 3.) Observation of Resident #44 on 09/10/25 at 12:01 P.M. revealed the resident was seated in room at the side of the bed. Black flying insects were noted landing on personal property and beverages. Resident #44 was observed swatting at the pest. On 09/09/25 at 1:34 P.M. interview with administrator during a review of facility pest control lacked documentation indicating resident rooms were being treated for black flies or gnats. The pest control documentation noted only employee areas and laundry. The administrator confirmed the presence of black flies in resident rooms and common areas. On 09/10/25 at 6:05 A.M. interview with Registered Nurse (RN) #448 stated she was scheduled and working 7:00 P.M. to 7:00 A.M. shift. Observations noted black flies throughout common areas and nurses station. RN #448 also verified black flies in various resident rooms. RN #448 stated she took her personal bag to her car due to the amount of black flies throughout the facility. 4.) Observation on 09/09/2025 at 12:43 P.M. of Resident #17's room revealed approximately five insects that were dark in color flying throughout Resident #17's room. Interview on 09/09/25 at 12:45 P.M. with Resident #17 revealed that the flying insects bother her, especially when she is eating and she does not feel the facility does an adequate job with pest control and that she has voiced her concern to the facility, with no resolution. Interview on 09/09/25 at 12:48 P.M. with Licensed Practical Nurse (LPN) #415 verified approximately five insects that were dark in color flying throughout Resident #17's room. 5.) Observation on 09/11/2025 at 1:19 P.M. of Resident #18's room revealed 37 small insects with wings that were dark in color on the privacy curtain in the middle of Resident #18's room, multiple small insects with wings that were dark in color on Resident #18's lunch tray and cups, and multiple other insects that were dark in color flying throughout Resident #18's room. Interview on 09/11/25 at 1:19 P.M. with Resident #18 revealed that the insects on the privacy curtain in the middle of her room, on her lunch try, and flying throughout her room bother her. She stated that she does not feel that the facility does an adequate job with pest control and that she has voiced her concern to the facility with no resolution. Interview on 09/11/25 at 1:20 P.M. with LPN #443 verified 37 37 small insects with wings that were dark in color on the privacy curtain in the middle of Resident #18's room, multiple small insects with (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wings that were dark in color on Resident #18's lunch tray and cups, and multiple other insects that were dark in color flying throughout Resident #18's room. 6.) Interview on 09/10/25 at 3:03 P.M. with Certified Nursing Assistant (CNA) # 468 revealed that throughout the facility small flying insects can be seen, especially in the medical storage room. Observation on 09/11/25 at 12:43 P.M. with the Director of Nursing (DON) of the medical supply storage room confirmed small flying insects were present. On top of a filing cabinet was a pizza box with leftover pizza inside and coming out of the box were small flying insects. Approximately three feet from the pizza box was the residents drink cart which contained a cooler full of ice, drink cups, lids, and straws. The small flying insects were seen in the vicinity of the drink cart. All sightings in the medical storage room were verified by the DON. 7.) Observation of Resident #45's room window on 09/09/25 at 2:38 P.M. revealed the resident's window screen failed to fit properly. There was an approximate one inch gap between the screen and the window which allowed for insects to enter the room. Further observation revealed gnats were flying around the resident's bed. Observation on 09/11/25 at 12:15 P.M. revealed Licensed Practical Nurse (LPN) #444 was speaking to Resident #45 at bedside and gnats were flying around the nurses head and the nurse had to swat them away. Interview with Resident #45 on 09/09/25 at 2:38 P.M. revealed gnats and horse flies would enter his room often and he would like the window screen repaired to fit the window. 8.) Observation of room [ROOM NUMBER] on 09/10/25 at 12:01 P.M. revealed three gnats were on the privacy curtain and multiple gnats were flying around the resident's meal trays. Interview with Residents #22 and #51 on 09/10/25 at 12:02 P.M. revealed gnats flew around them as they were trying to eat their meals and they wished the facility had an active pest control plan. Review of facility pest activity report noted treatment applications completed between 06/27/25 and 08/25/25. On 06/27/25 treatment was initiated for fungus gnats in employee areas. On 07/28/25 treatment for house flies, small fruit flies in employee areas, On 08/25/25 treatments were applied for house flies and small flies in employee areas. No documented treatments included resident areas. Continued observations throughout the survey week revealed small flying insects in the conference room, in residents' rooms, and at the nurses' stations. Review of the facility policy titled, “Homelike Environment”, dated February 2021, revealed residents are provided with comfortable and homelike environment. This deficiency represents non-compliance investigated under Complaint Numbers 2593504, 2608577, and 2593728.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident interview, and staff interview the facility failed to properly complete the Minimum Data Set (MDS). This affected one resident (#30) reviewed for vision. The facility census was 60.Review of Resident #30's medical record revealed an admission date of 02/03/25. Diagnoses included acute kidney failure, altered mental status, and malnutrition. Review of Resident #30's quarterly Minimum Data Set (MDS) dated [DATE] revealed he had an intact cognition. His vision was marked as adequate and no corrective lenses were required. Review of Resident #30's most recent care plan revealed the resident received optical services, but the record was absent to vision loss. Review of Resident #30's physician note dated 03/24/25 revealed previous to entering the facility he began loosing his vision and became nearly blind. Review of Resident #30's outside eye exam report dated 04/09/25 revealed the resident had other eye problems and required a referral for cataract surgery. The resident had dense cataract in the left eye and moderate in the right. Review of Resident #30's social service note dated 05/22/25 revealed the resident was concerns about seeing the eye doctor and was concerns about loosing his vision. Interview with Licensed Practical Nurse (LPN) #463 on 09/11/2025 at 1:09 P.M. revealed Resident #30 was seen by an outside optometrist in April 2025 and received a referral for a optical surgeon. The LPN was unsure how that was affecting the resident's vision. Interview with MDS Coordinator #462 on 09/11/25 at 1:45 P.M. revealed part B of the MDS assessment information was received from social services and as part of the resident interview. There was a clinical assessment that assessed vision which is also where the information was received. The MDS Coordinator agreed Resident #30's vision assessment was inaccurate. Interview with Social Service Director #460 on 09/11/2025 at 1:50 P.M. revealed she completed the vision section of the MDS by reviewing their medical record and just knowing the residents. She failed to complete the assessment as directed. Interview with Resident #30 on 09/11/2025 at 2:02 P.M. revealed he had no vision in his left eye and low vision in his right. He had been waiting for a long period of time to see the surgeon. Review of the facility policy titled Resident Assessments revised November 2019 revealed a comprehensive assessment of every resident's needs is made at intervals designated by Omnibus Budget Reconciliation Act (OBRA) and Prospective Payment System (PPS) requirements. The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews according to the requirements.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on medical record review, staff interview and review of facility policy the facility failed to ensure the baseline care plan was individualized to meet resident needs. This affected one (#08) of one resident revealed for base line care plans. The facility census was 60. Review of the medical record for Resident #08 revealed an admission date of 07/02/25 with diagnoses of acute cystitis, cerebral infarction, heartburn, anorexia, personal history of transient ischemic attack (TIA), nicotine dependence, hypomagnesemia, other specified health status, major depressive disorder, adult failure to thrive, altered mental status (AMS), Alzheimer's disease, other acquired deformity of head, and unspecified protein-calorie malnutrition. Review of the admission Minimum Data Set (MDS) assessment for Resident #08 revealed a Brief Interview of Mental Status (BIMS) score of 06, indicating Resident #08 was severely cognitively impaired. Further review of the MDS assessment for Resident #08 revealed she required substantial or maximal assistance with all Activities of Daily Living (ADLs). On 09/09/25 at 1:45 P.M. the care plan for Resident #08 was reviewed and there were no care-planned interventions to address the residents diagnosis of Alzheimer's disease or her ADL needs. Interview on 09/15/25 at 10:45 A.M. with the Director of Nursing (DON) verified there were no care-planned interventions to address Resident #08's diagnosis of Alzheimer's disease or her ADL needs.Review of the facility policy titled, Resident Participation-Assessment/Care Plans, dated February 2025, revealed the care planning process includes an assessment of the resident's strengths and his or her needs.

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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, medical record review, staff interview, and resident interviews, the facility failed to ensure venous ulcer preventions were in place. This deficient practice affected one (#45) of one residents reviewed for venous ulcers. The facility census was 60.Review of Resident #45's medical record revealed an admission date of 05/02/25. Diagnoses included local infection of the skin and subcutaneous tissue, chronic venous hypertension with ulcer of the left and right lower extremity, non-pressure chronic ulcer of the left foot and right lower leg with fat layer exposed, pressure-induced deep tissue damage of the right buttock, pressure-induced deep tissue damage of the right sacral region, pressure-induced deep tissue damage of the left buttock, hypertension, and muscle wasting. Review of Resident #45's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident was cognitively intact. Resident #45 was always incontinent of bowel and frequently incontinent of urine, there was a risk for pressure ulcers. Resident #45 had two arterial and venous ulcers and moisture associated with skin damage which required a pressure-reducing device for the bed and non-surgical dressings. Review of Resident #45's most recent care plan revealed the resident had a venous ulcer related to peripheral vascular disease. The resident had the potential impairment to skin integrity related to fragile skin. Interventions included encouraging the resident to elevate heels off of the bed and the use for a low air loss mattress to protect the skin while in bed. The resident has risk for alterations in skin integrity and actual wounds with the potential for pressure ulcer development related to the disease process of ulcers and immobility. Review of Resident #45's physician order dated 05/07/25 was to apply offloading boots to bilateral lower extremities every shift for skin integrity. The boots may be removed when out of bed. Review of Resident #45's physician order dated 05/07/25 revealed a low air loss mattress was to be provided at all times to the bed with functioning checked every shift. The nurse manager was to be notified if the low-air mattress needed to be replaced. Review of Resident #45's physician order dated 05/14/25 revealed compression stockings were to be applied in the morning and removed at bedtime for wound care. Review of the local wound care and hyperbaric center Physician Assistant #02's notes dated 09/10/25 revealed lymphedema and venous insufficiency were located on the bilateral lower extremities. The lower extremity wounds required offloading to promote healing and leg elevation to decrease edema. Observation on 09/09/25 at 10:50 A.M. revealed Resident #45's low air loss mattress failed to be functioning. The mattress was flat, and a red light was flashing on the control panel. Both of Resident #45's feet were lying flat on the bed. Resident #45 was not wearing either the compression stockings or the off-loading boots. Interview with Certified Nursing Assistant (CNA) #402 on 09/09/25 at 10:56 A.M. verified the low air mattress on Resident #45's bed was not working properly, and she would notify the nurse. CNA #402 also verified that the resident's compression stocking failed to be applied in the morning and that (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #45 did not have off-loading boots in place. CNA #402 went to the closet and pulled out two large boots lined with fleece and one black boot. The boots were entwined together. Resident #45 stated the fleece boots did not belong to him. CNA #402 stated she was unaware of which boots were the residents. Interview with Resident #45 on 09/09/25 at 10:56 A.M. revealed the resident wished to have the compression stocking applied, but staff failed to do so. The resident stated he had requested a new mattress on multiple occasions as he was lying flat on a hard surface, but that a new mattress has yet to be supplied. Telephone interview with the wound care and hyperbaric center Wound Specialist Physician Assistant #02 on 09/11/25 at 10:26 A.M. revealed Resident #45's wounds were slow to heal and the lack of a functioning air mattress and not elevating the residents' lower extremities could contribute to the slow healing of Resident #45's wounds. Observation of Resident #45 on 09/11/25 at 10:44 A.M. revealed a new air mattress had been placed on Resident #45's bed and was functioning. Compression stockings were in place, however the resident had no offloading boots in place. Interview with Licensed Practical Nurse (LPN) #442 on 09/11/25 at 10:46 A.M. verified Resident #45's did not have the offloading boots in place. The facility provided an Emerald Selectis User Manual for low air mattress model number 61057 referred to a manufacturer website. Review of the Emerald Selectis Model #61057 alternating pressure pump and mattress User Manual found at the following website: https://d16g73uzcqb35u.cloudfront.net/img/product/6a/6a4348c9-1986-4ce3-bbaf-04adc9e0445c/6105761058 stated there was a visible indicator (yellow or red) warns that the pressure is below a preset or user-defined level. There is also an audible and visible alarm which turns on after 2.5 minutes when the pressure is low. Also, a mute button is available to mute the audible alarm. Review of wound care policy revised October 2010. Verify there is a physicians order for this procedure. Review the residents care plan to assess for any special needs of the resident. This deficiency represents non-compliance investigated under Master Complaint Number 2652561 and Complaint Numbers 2576517, 2608577, and 2593504.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, review of facility medical record, and review of facility policy, the facility failed to ensure residents with pressure ulcers received necessary treatment and services to promote healing. This affected two resident (#10 and #45) of two residents reviewed for pressure. The facility census was 60. 1.) Review of the medical record for Resident #10 revealed an admission date of 07/11/25 with diagnoses of pressure ulcer of sacral region stage four, type two diabetes mellitus (DM2), long-term (current) use of insulin, cutaneous abscess of right lower leg (RLL), acute embolism and thrombosis of left femoral vein, cutaneous abscess of right foot, encounter for other specified surgical aftercare, retention of urine, hypotension (HOTN), hypertension (HTN), hyperlipemia, obstructive sleep apnea (OSA), major depressive disorder, respiratory disorders in disease classified elsewhere, anxiety disorder, atrial fibrillation (a. fib), and morbid obesity due to excess calories. Review of the most recent quarterly Minimum Data Set (MDS) Assessment, dated 07/11/25, revealed a Brief Interview of Mental Status (BIMS) score of 15, indicating Resident #15 was cognitively intact. Review of the medical record revealed Resident #10 revealed a physician order, dated 09/09/25, for the stage four pressure ulcer on his coccyx to be cleansed with wound cleanser and sterile gauze, packed with calcium alginate (a wound dressing that forms a gel when in contact with exudate (a substance secreted from a wound) which forms to the contours of the wound to facilitate wound healing), and covered with Dermafilm (a wound dressing that promotes healing by protecting wounds). This dressing change was ordered to be completed once daily on day shift and as needed (PRN). Interview on 09/15/25 at 9:09 A.M. with Resident #10 revealed he had a large bowel movement the night before and the physician-ordered dressing for the stage four pressure ulcer on his coccyx came off while he was being cleaned up and had not been replaced. Resident #10 stated that he had requested his dressing be replaced multiple times and it had not been done. He stated that his wound was uncomfortable without the dressing in place. Interview on 09/15/25 at 9:15 A.M. with Licensed Practical Nurse (LPN) #403 revealed she had no knowledge that Resident #10 ' s physician-ordered dressing for the stage four pressure coccyx pressure ulcer was not in place as she was not notified in report and there was no documentation in the electronic medical record. Observation on 09/15/25 beginning at 9:20 A.M. of incontinence care for Resident #10 revealed the physician-ordered dressing for the stage four pressure coccyx pressure ulcer was not in place. Interview with LPN #403 at the time of observation verified this finding. 2.) Review of Resident #45 ' s medical record revealed an admission date of 05/02/25. Diagnosis included local infection of the skin and subcutaneous tissue, chronic venous hypertension with ulcer of the left and right lower extremity, non-pressure chronic ulcer of the left foot and right lower leg with fat layer exposed, pressure-induced deep tissue damage of the right buttock, pressure-induced deep tissue damage of the right sacral region, pressure-induced deep tissue damage of the left buttock, hypertension, and muscle wasting. Review of Resident #45 ' s quarterly Minimum Data Set (MDS) dated [DATE] revealed he was cognitively intact. He was always incontinent of bowel and frequently incontinent of urine. There was (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a risk for pressure ulcers, had a stage III pressure ulcer to the bilateral gluteal area and had two arterial and venous ulcers and moisture associated with skin damage. He required a pressure-reducing device for the bed and non-surgical dressings. Review of the current physician orders for the stage III pressure ulcer to the bilateral gluteal area included for the area to be cleansed with a wound solution, zinc oxide to be applied followed by a bordered dressing three times a week. The pressure ulcer was to be offloaded using an alternating air mattress. Observation of Resident #45 ' s buttock wound on 09/15/25 at 1:45 P.M. revealed the buttock area was red and was open to air. There were four deep red areas; two on each side of the intergluteal cleft. No dressing was in place as it was left open to air. Review of the facility policy titled, Wound Care, dated October 2010, revealed the purpose of wound care is to provide the care of wounds to promote healing. This deficiency represents non-compliance investigated under Complaint Numbers 2576517 and 2612561.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366041	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Addison Heights Health and Rehabilitation Center	3600 Butz Rd Maumee, OH 43537

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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 observation, medical record review, staff interview, and facility policy, the facility failed to ensure fall prevention devices were implemented as indicated. This affected two of two residents (#38, #44) reviewed for fall prevention interventions in a facility census of 60. 1.Resident #38 admitted to the facility on [DATE] with the diagnosis including, bipolar disorder, dysphagia, epilepsy, disorder of psychological development, major depression, and acute and chronic respiratory failure with hypoxia. According to the most recent minimum data set assessment dated [DATE] assessed Resident #38 with severely impaired cognition, exhibited physical and other behavioral symptoms, required substantial to maximal assistance with activities of daily living, incontinent of bowel and bladder, received mechanically altered diet, at risk for pressure ulcer development with no current skin breakdown, received antibiotic, antidepressant, antianxiety and anticonvulsant medications. On 08/07/25 a nursing plan of care was implemented to address Resident #38 risk for falls related to confusion and unaware of safety needs. Interventions included the following; Anticipate and meet The resident's needs. Be sure resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Follow facility fall protocol. According to physician orders noted on 08/20/25 a Soft Helmet to encourage resident to wear at all times. Review of progress notes revealed on 09/05/25 at 9:00 A.M. Resident #38 had a fall in common area without injury. No documentation indicated what fall prevention measures were in place at the time of the fall. On 09/06/25 at 5:28 P.M. progress notes documented fall was not witnessed. Fall occurred in the hallway. Resident was in a hurry / rush at the time of the fall. The reason for the fall was not evident. No injury was recorded. No documentation indicated fall preventive measures in place when the fall occurred. On 09/06/25 a fall risk assessment scored Resident #38 at risk for falling due to three or more falls occurring in the last 3 months and intermittent confusion. Observation on 09/09/25 at 8:24 A.M., 09/10/25 at 10:15 A.M., and 12:01 P.M., 09/11/25 at 10:56 A.M. noted Resident #38 unattended by staff, ambulating throughout the facility bare foot and no helmet applied. Additional review of progress notes dated 09/10/25 at 1:10 P.M. Resident has had multiple falls this week. New interventions included in place for frequent checks in morning, medication review, and lab orders. No documentation indicated fall interventions in place at the time of the falls. Review if facility falls and fall risk policy revised March 2018. The staff with the input of the attending physician will implement a resident centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention (e.g., dizziness or weakness) has resolved. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. 2. Resident #44 admitted the facility on 01/23/23 with the diagnosis including, congestive heart failure, benign prostatic hyperplasia, chronic obstructive pulmonary disease, epidural hemorrhage, bipolar disorder, hypertension, anemia, vascular myelopathies, and fracture of fourth lumbar vertebra. According to the most current minimum data set assessment dated [DATE] Resident #44 was assessed with intact cognition, no behaviors, range of motion impairment to the bilateral upper extremities, utilized a walker or wheelchair for mobility, independent with transferring, required substantial to maximal assistance with activities of daily living, sustained two or more falls since admission. On 10/11/23 a nursing plan of care was implemented to address Resident #44 risk for falls related to deconditioning, gait and balance problems. Interventions included the following; Anticipate (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and meet The resident's needs. Be sure The resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Ensure bed in locked. Ensure resident is wearing appropriate fitting shoes. Ensure that The resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair. Follow facility fall protocol. Grippy socks with ambulating. Nonskid strips to bedside. Siderail to be replaced with grab bar.On 07/21/25 a physician order was initiated for half Side Rails to right and left side of bed to promote independence with bed mobility, self positioning, and transfers.Review of progress notes revealed on 06/23/25 at 10:28 P.M. Resident #44 sustained an unwitnessed fall while ambulating in room and tried to sit in chair. Resident reported tripping over his own feet because his shoes were too big. New intervention was to ensure resident is wearing appropriately fitting shoes. No documentation recorded fall interventions in place at the time of the fall. On 07/14/25 at 7:20 P.M. Resident #44 sustained an unwitnessed fall and found on floor in room. Resident reported he attempted to stand up and lost his balance and slipped onto the floor. No documentation recorded fall interventions in place at the time of the fall. On 07/21/25 at 7:45 A.M. progress notes document Resident #44 stood up in room and fell to his bottom. New intervention to increase area of non-skid strips in front of bed. Investigation noted Resident #44 to state he slipped and lost his grip on the floor while trying to stand up. No documentation recorded fall interventions in place at the time of the fall. Observation on 09/08/25 at 11:11 A.M. with Wound Care Specialist Certified Nurse Practitioner (WCS) #1 discovered Resident #44 seated on the edge of the bed and sliding from the bed. WCS #1 proceeded to assist Resident #44 with proper seating adjustment. Resident #44 did not have slip resistant footwear applied and no access to a siderail/grabrail was provided. On 09/09/25 at 10:31 A.M. resident was in bed with feet elevated, no slip resistant socks or footwear and no accessible siderail or grab bar. At 12:30 P.M. resident was seated at bedside in a chair with eyes closed. No non-slip shoes/footwear was in place and grabrail/siderail not accessible. On 09/10/25 6:15 A.M. resident seated at bedside in reclining chair. No slip resistant shoes or footwear were applied. At 8:21 A.M. Resident #44 was up at bedside eating breakfast. No slip resist foot wear was applied or siderail/grabrail was accessible. At 12:01 P.M. Resident #44 was observed seated at bedside in a chair without slip resistant socks applied and no accessible siderails applied to bed. Observation on 09/10/25 at 12:55 P.M. with Licensed Practical Nurse (LPN) #403 verified Resident #44 was up seated in a bedside chair without non-slip footwear or siderail/grab bar in use to bed. Review if facility falls and fall risk policy revised March 2018. The staff with the input of the attending physician will implement a resident centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention (e.g., dizziness or weakness) has resolved. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and facility policy the facility failed to provide tracheostomy care and maintenance as ordered by the physician. This affected one of one residents (#6) reviewed for tracheostomy care in a facility census of 60. Resident #6 admitted to the facility on [DATE] with the diagnosis including, chronic respiratory failure with hypoxia, tracheostomy, acute kidney failure, atrial fibrillation, type 2 diabetes mellitus, hypertension, and anxiety disorder. According to the most current minimum data set assessment dated [DATE] assessed Resident #6 with intact cognition, no listed behaviors, dependent on staff for the completion of activities of daily living, received oxygen and tracheostomy treatments. Review of physician orders dated 01/09/22 noted tracheostomy (trach) skin around stoma site and under ties to be assessed during trach care every shift. Notify physician if redness, irritation, drainage, alteration to skin integrity. In addition, trach care is to be completed every shift and as needed. On 09/09/25 at 10:41 A.M. Resident #6 was observed seated at bedside with supplemental oxygen provided via nasal cannula at three liters per minute. Resident #6 had a tracheostomy (trach) in place with the trach capped and a dressing to the stoma which appeared to be tattered. Interview with Resident #6 at the time revealed she was unaware when the trach care had been provided and care was not provided each shift On 09/09/25 at 2:37 P.M. observation with Licensed Practical Nurse (LPN) #442 noted trach care supplies obtained and placed at Resident #6 bedside. LPN #442 proceeded to don surgical gloves and associated personal protective equipment. LPN #442 removed the dressing to the trach stoma and identified moderate green drainage. LPN #442 indicated the dressing appeared soiled and tattered and did not appear to be changed the previous shift on 09/08/25 between 7:00 P.M. and 09/09/25 at 7:00 A.M. LPN #442 continued providing trach care and removed the trach inner cannula which was observed with a build-up of mucus inside. LPN #442 indicated the inner cannula was to be changed during each trach care and did not appear to be replaced during the previous shift. On 09/10/25 at 5:50 A.M. interview with Registered Nurse (RN) #440 stated Resident #6 trach care did not populate in treatment administration records to be completed during her 7:00 P.M. to 7:00 A.M. shift. RN #440 stated trach care would not be performed during her shift. On 09/11/25 at 5:56 A.M. interview with LPN #417 revealed they were assigned to Resident #6 on 09/08/25 between 7:00 P.M. and 09/09/25 at 7:00 A.M. LPN #417 stated the extent of tracheostomy (trach) care provided was an observation of the tracheostomy stoma. LPN #417 confirmed they did not cleanse the trach or change the dressing and proceeded to document the treatment as completed in the treatment administration record. LPN #417 stated they were not aware on how to complete trach care and was unfamiliar with the policy and procedure. Observation at the time discovered no access to the policy and procedure at the nurses station. Review of facility Tracheostomy Care policy dated October 2023. Tracheostomy tubes should be changed as ordered and as needed (at least monthly). Tracheostomy care should be provided as often as needed, at least once daily for old, established tracheostomies, and at least every eight hours for residents with unhealed tracheostomies.