STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366052	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gables Care Center	351 Lahm Drive Hopedale, OH 43976

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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 - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility's infection prevention and control program, review of the facility's legionella prevention program, review of infection logs and reports, observations, interviews with facility staff, review of Centers for Disease Control (CDC) guidelines, and facility policy review, the facility failed to identify and address infection trends, failed to adequately monitor water temperatures per the facility's water management plan, failed to ensure gloves were appropriately changed during incontinence care for Resident #74, and failed to perform hand hygiene to prevent the spread of infection prior to insulin administration for Resident #40. This had the potential to affect 75 residents residing in the facility. The facility census was 75.Findings include: 1.Review of the facility's monthly infection control logs for November 2025, December 2025, January 2026, February 2026, March 2026, and April 2026 revealed 29 treated urinary tract infections (UTI). Further review revealed 10 UTI's were tested positive for the bacteria E.coli. Seven of the UTI's did not have a culture or corresponding organism, and six UTI's were cultured for other identified organisms. Review of the monthly infection reports for November 2025, December 2025, January 2026, February 2026, March 2026, April 2026 revealed no trends noted for each month. Further review revealed no data collected or analyzed for specific organism on each monthly report. Review of the monthly education provided by the infection preventionist, Registered Nurse (RN) #80, from November 2025 to April 2026 revealed no education specific to the prevention of UTIs or preventing the spread of E. coli. Interview on 04/30/26 at 10:30 A.M. with the facility identified infection preventionist, RN #80 revealed that E.coli was the most common organism the facility had cultured for UTI's. Further interview revealed RN #80 reporting the most common reason for E. coli to be present in a urine would be inadequate personal hygiene or inadequate incontinence care. RN #80 denied doing any infection control and prevention education with staff related to incontinence care or the spread of E. coli. RN #80 denied trending infections by organism type on her monthly infection reports and had only observed E.coli as common organism but had not completed any further investigation as possible cause. Review of the facility infection prevention and control program dated 04/02/22 and revised/reviewed on 12/08/25 revealed the facility would designate an infection preventionist who oversee the program and complete a system of surveillance to prevent, identify, report, and investigate infection diseases. 2.Review of the facility Legionella (a water borne bacteria that can lead to severe pneumonia and other infections) water management program revealed, hot water heaters/boilers are checked daily (temp 135-160 degrees). Further review of the water temperature logs revealed weekly water temperature checks for residents' rooms. There was no evidence of daily water temperature checks (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	for the water heater/boiler system. Interview on 04/30/26 at 1:15 P.M. with the Maintenance Director #842 revealed he was unaware of needing to get daily water temperature checks and had not been completing them. Review of the Center for Disease Control (CDC) Toolkit for Controlling Legionella in Common Sources of Exposure version 1.3 published 02/17/26 revealed recommendations to store hot water at temperatures above 140 degrees F (60 degrees C) and ensure hot water in circulation does not fall below 120 degrees F (49 degrees C). Recirculate hot water continuously, if possible. The tool kit further recommends, monitor temperature, disinfectant residuals, and pH frequently based on performance of water management program or Legionella performance indicators for control. Adjust measurement frequency according to the stability of performance indicator values. For example, the measurement frequency should be increased if there is a high degree of measurement variability. The favorable temperature for growth of Legionella is 77 to 113 degrees Fahrenheit. 3. Observation on 04/30/26 at 9:43 A.M. With Certified Nursing Assistant (CNA) #911 revealed Resident #74 was provided with incontinence care. CNA #911 had supplies ready (basin, wash cloths, soap and water), completed hand hygiene, and applied gloves. Resident #74 was being provided with incontinence care after a bowel movement. CNA #911 cleansed the resident's perineal area, then rolled onto her left side, removed the dirty brief, and cleaned Resident #74's buttocks. CNA #911 did not change gloves or perform hand hygiene after removing the soiled brief and providing perineal care. CNA #911 used the same gloves and scooped Desitin (a topic skin moisture barrier cream) from a multi-use container [NAME] was applied to the residents' gluteal folds. A new brief was tucked under resident #74. Resident #74 was then rolled onto her back. CNA #911 then scooped Desitin with the same gloves in the same multi use container and applied the [NAME] cream to the resident's perineal area. CNA #911 changed her gloves at this time and did not perform hand hygiene. The brief was then fastened and pants were put on the resident, and blanket was pulled up. CNA #911 then told Resident #74 she would be back to assist her to her chair. CNA #911 picked up the garbage bag and left the room at 9:50 A.M. Interview on 04/30/26 at 9:50 A.M. with CNA #911 confirmed she did hygiene before beginning incontinence care and did not perform it after that. CNA #911 reported she changed her gloves one time after applying the Desitin cream. CNA #911 confirmed she scooped Desitin from the container with the same gloves she wore during incontinence care. Review of the facility policy titled hand hygiene revised 12/08/25 revealed the use of gloves does not replace hand hygiene. If a task requires gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves. Hand hygiene is a general term for cleaning your hands by hand washing with soap and water or the use of an antiseptic hand rub, also known as alcohol based hand rub (ABHR). 4. On 04/29/26 between 11:45 A.M. and 12:03 P.M., observation of Resident #40's glucose monitoring and insulin administration revealed Licensed Practical Nurse (LPN) #87 washed her hands at the sink, gathered supplies and went to Resident #40's room. LPN #87 donned gloves, cleansed a finger on the resident's right hand and used a lancet to obtain blood for the glucose monitoring strip. There was not enough blood return from the site and LPN #87 informed the resident she would have to access another finger to get an adequate amount of blood for the glucose monitoring device. LPN #87 obtained a second alcohol swab and using the lancet, obtained adequate blood supply from a finger on the resident's left hand. The residents glucose level was 262. LPN #87 stated she needed to return to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the medication cart to get another alcohol swab to administer the insulin, removed her gloves, threw the gloves in the trash can, left Resident #40's room without washing her hands, went to the medication cart and returned to the resident's room with another alcohol swab. LPN #87 donned a new pair of gloves without washing her hands, cleansed the resident's upper left arm and administered Resident #40's insulin. LPN #87 then removed her gloves and went to the resident's bathroom and washed her hands. On 04/29/26 at 12:03 P.M., interview with LPN #87 verified she did not wash her hands after removing her gloves after completing the glucose monitoring, left the residents room without washing her hands, returned to the room and did not wash her hands prior to redonning gloves to administer Resident #40's insulin. Review of the policy Medication Administration revised 12/09/25 revealed medications were to be administered by licensed nurses or other staff legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to ensure residents were provided baseline care plans as required. This affected five residents (#6, #38, #84, #102) of 15 residents sampled for baseline care plans. The census was 75.Findings include: 1. Record review revealed Resident #6 admitted to the facility on [DATE] with diagnoses including cardiomegaly, pleural effusion, anxiety, constipation, and atrial fibrillation. Review of Resident #6 base line care plan dated 02/19/26 and baseline care plan summary dated 02/19/26 revealed no documentation of the resident being provided information or received a copy of the baseline care plan until seven days later on 02/26/26 when the resident signed the document. Interview with 04/27/26 at 12:37 P.M. with Resident #6 revealed they did not believe they had been part of a care plan conference of any kind. Interview on 04/29/26 at 2:30 P.M. with ADON #852 verified the signature of Resident #6 baseline care plan was dated 02/26/26 and the baseline care plan was dated as completed on 02/19/26. 2.Medical record review revealed Resident #84 was admitted on [DATE] with diagnoses including hypertension, acute respiratory failure with hypoxia, abnormalities of gait and mobility, acute myocardial infarction, ventricular tachycardia and fibrillation, hypotension, cerebral infarction and exacerbation of chronic obstructive pulmonary disease. The resident was cognitively intact for daily decision-making. Review of the unsigned/undated electronic Baseline Care Plan - V2 dated 03/19/26 revealed Resident #84 was admitted on [DATE]. There was no evidence the resident was provided the information or had received a copy of the baseline care plan as of 04/29/26. On 04/27/26 at 4:25 P.M., interview with Resident #84 revealed he had not had a baseline care plan meeting or received a copy of his baseline care plan to date. On 04/29/26 at 2:29 P.M., interview with Assistant Director of Nursing (ADON) #852 verified Resident #84 was not provided a baseline care plan within the required timeframe after admission to the facility. ADON #852 verified the above resident was provided their baseline care plans on 04/29/26 with a signature only and did not document the date they were received. ADON #852 verified the facility practice was to provide the baseline care plan within 48 hours of admission and the above were not completed timely. 3. Medical record review revealed Resident #38 was admitted on [DATE] with diagnoses including senile degeneration of the brain, dysphagia, muscle wasting and acute pulmonary insufficiency following nonthoracic surgery. The resident was severely impaired for daily decision-making. Review of the unsigned/undated electronic Baseline Care Plan - V2 dated 04/14/26 revealed Resident #38 was admitted on [DATE]. There was no evidence the resident representative was provided the baseline information or had received a copy of the baseline care plan as of 04/29/26. On 04/29/26 at 2:29 P.M., interview with ADON #852 verified Resident #38 was not provided a (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	baseline care plan within the required timeframe after admission to the facility. ADON #852 verified the above resident was provided their baseline care plans on 04/29/26 with a signature only and did not document the date they were received. ADON #852 verified the facility practice was to provide the baseline care plan within 48 hours of admission and the above were not completed timely. 4. Medical record review revealed Resident #102 was admitted on [DATE] with diagnoses including dependence on renal dialysis, hypertension and peripheral vascular disease. The resident was cognitively intact for daily decision-making. Review of the unsigned/undated electronic Baseline Care Plan - V2 dated 04/14/26 revealed Resident #102 was admitted on [DATE]. There was no evidence the resident was provided the baseline information or had received a copy of the baseline care plan as of 04/29/26. On 04/28/26 at 7:30 A.M., interview with Resident #102 revealed she had not had a baseline care plan meeting or received a copy of her baseline care plan to date. On 04/29/26 at 2:29 P.M., interview with ADON #852 verified Resident #102 was not provided a baseline care plan within the required timeframe after admission to the facility. ADON #852 verified the above resident was provided their baseline care plans on 04/29/26 with a signature only and did not document the date they were received. ADON #852 verified the facility practice was to provide the baseline care plan within 48 hours of admission and the above were not completed timely.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, drug information review, policy review and interview, the facility failed to ensure medications were administered as ordered. There were four errors out of 25 medication administration opportunities for an error rate of 16%. This affected three residents (#40, #66 and #89) of six residents reviewed for medication administration. The facility census was 75. Findings include:1.Medical record review revealed Resident #89 was admitted on [DATE] with diagnoses including benign prostatic hyperplasia (BPH) with lower urinary tract symptoms.Review of the Order Summary Report dated April 2026 revealed Resident #89 was to receive Flomax 0.4 milligrams (mg) once a day for BPH.On 04/29/26 at 8:00 A.M., observation of the morning medication administration revealed Licensed Practical Nurse (LPN) #844 dispensed Resident #89's Flomax capsule from the individual packaging onto the top of the medication cart. The top of the medication cart was observed to have scattered white granules on it, LPN #844 donned gloves, picked up the capsule, put the capsule into the medication cup and administered the medications to the resident. On 04/29/26 at 8:09 A.M., interview with LPN #844 verified the above observation and a new capsule should have been administered due to contamination.2. Medical record review revealed Resident #66 was admitted on [DATE] with diagnoses including calculus of kidney and ureter, anemia, iron deficiency anemia, and vitamin D deficiency.Review of the Order Summary Report dated April 2026 revealed Resident #66's morning medications included Calcium Carbonate 600 milligrams (mg) with Vitamin-D 5 micrograms (mcg) for supplement and ferrous sulfate 325 mg (65 Fe) daily for iron deficiency anemia.On 04/29/26 at 8:13 A.M., observation revealed LPN #831 prepared Resident #66's morning medications including dispensing Calcium Carbonate 600 mg with Vitamin-D 10 mcg and ferrous sulfate 325 mg, the medications were placed in a plastic sleeve and crushed. The crushed medications were then put in a small amount of applesauce and administered to Resident #66. On 04/29/26 at 8:16 A.M., interview with LPN #831 verified the above observation. On 04/29/26 at 12:50 P.M., interview with the Director of Nursing (DON) verified the above errors and stated she was notifying the physician.Review of the National Library of Medicine: Iron Supplementation dated 2026 revealed for best absorption, the recommendation is to take iron at least 30 minutes before a meal or two hours before taking other medications.Review of the Cleveland Clinic: Iron Supplement (Ferrous Sulfate) dated 05/24/22 revealed you should not crush iron pills. Iron tablets and capsules are designed to be swallowed whole to ensure proper absorption and to prevent side effects like stomach irritation, nausea, and teeth staining.3.Medical record review revealed Resident #40 was admitted on [DATE] with diagnoses including diabetes mellitus.Review of the Order Summary Report dated April 2026 revealed Resident #40 received Humalog Kwikpen subcutaneous 25 units before meals and at bedtime.On 04/29/26 between 11:45 A.M. and 12:03 P.M., observation revealed LPN #87 obtained a Resident #40's HumaLOG (lispro insulin, a fast-acting insulin) kwikpen and a new needle from the medication cart, completed glucose monitoring and asked Resident #40 where he would like his insulin shot. LPN #87 dialed 25 units on the Humalog kwikpen and administered the insulin in the resident's left upper arm. LPN #87 was not observed priming the Humalog kwikpen prior to administration of the insulin. On 04/29/26 at 12:03 P.M., interview with LPN #87 verified she did not prime the insulin pen prior to administration. On 04/29/26 at 12:51P.M., interview with the DON verified insulin pens should be primed prior to dosing insulin.Review of the policy: Insulin Pen revised 12/08/25 revealed it was the policy of the facility to use insulin pens in order to improve the accuracy of insulin dosing, provide increased resident comfort and serve as a teaching aid to prepare residents for self-administration of insulin therapy upon discharge. Insulins pens were to be primed prior to each use to avoid collection of air in the insulin reservoir. To prime the insulin pen, dial two units by turning the dose selector clockwise, with the needle pointing up, push the plunger and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	drop appears. LPN 4/29/26 at 1203pm + didn't wash handsReview of the policy: Medication Administration revised 12/09/25 revealed medications were to be administered by licensed nurses or other staff legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Ensure the six rights of medication administration were followed and administer medication as ordered in accordance with manufacturer specifications including not crushing medications with do not crush instructions.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents or their representative received written notice which specified the duration of the facility's bed-hold policy at the time of transfer. This affected two residents (#65 and #74) of three residents reviewed for hospitalization. The facility census was 75. Findings include: 1.Record review revealed Resident #65 admitted to the facility on [DATE] with diagnoses including obstructive sleep apnea, chronic respiratory failure, heart failure, myocardial infarction, nicotine dependence, and type two diabetes. Review of Resident #65's progress note dated 04/12/26 at 11:27 P.M. revealed Resident #65 had complaints of shortness of breath, lung sounds were diminished with little air movement, and the resident's oxygen saturation level was 91 percent (%) on room air. The resident was given an albuterol breathing treatment, after which Resident #65 stated they did not feel any better and had generalized abdominal pain. The facility's Medical Director was made aware. Emergency Medical Services was contacted for transport to a local emergency room, and the resident's family was notified of the transfer. Review of Resident #65's bed-hold notice dated 04/12/26 revealed no documentation regarding how many bed-hold days had been used, nor the number of bed-hold days remaining.2. Record review revealed Resident #74 admitted to the facility on [DATE] with diagnoses including pulmonary hypertension, type two diabetes, Chronic obstructive pulmonary disease, stage 4 chronic kidney disease, insomnia, bradycardia, and atrial fibrillation. Review of Resident #74's progress note dated 03/29/26 at 1:55 P.M. revealed the resident had complaints of chest pain radiating into her left jaw and clavicle. Resident #74 stated the pain was sharp and nothing like she had ever had before. The Medical Director was notified and Resident #74 was sent to a local emergency room, and the resident's family was notified of the transfer. Review of Resident #74's bed-hold notice dated 01/17/26 revealed the resident was discharged to the hospital. The bed-hold notice revealed no documentation regarding how many bed-hold days had been used, nor the number of bed-hold days remaining.Review of Resident #74's bed-hold notice dated 03/29/26 revealed the resident was discharged to the hospital. The bed-hold notice revealed no documentation regarding how many bed-hold days had been used, nor the number of bed-hold days remaining.Interview on 04/29/26 at 10:35 A.M. with Social Service Designee (SSD) #12 confirmed bed-hold notices for Resident #65 on 04/12/26 and Resident #74 on 03/29/26 and 01/17/26 did not include documentation of the number of bed-hold days remaining, or bed hold days used.Review of the facility policy titled Bed Hold Notice revised 12/08/25 revealed at the time of a transfer to the hospital or a therapeutic leave, the facility will provide the resident and/or the representative written information that specifies the duration of the state bed hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; the reserve bed payment and policy in the state plan policy, if any. The facility policies regarding bed hod periods include allowing a resident to return to the next available bed.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to ensure comprehensive assessments were accurate. This affected two residents (#38 and #84) of 24 residents reviewed for comprehensive assessments. The census was 75. Findings include: 1. Medical record review revealed Resident #84 was admitted on [DATE] with diagnoses including hypertension, acute respiratory failure with hypoxia, abnormalities of gait and mobility, acute myocardial infarction, ventricular tachycardia and fibrillation, hypotension, cerebral infarction and exacerbation of chronic obstructive pulmonary disease. Review of the admission Minimum Data Set 3.0 (MDS) assessment dated [DATE] and the 5-day MDS assessment dated [DATE] revealed Resident #84 was cognitively intact for daily decision-making and had adequate vision with the use of corrective lenses. On 04/27/26 at 3:53 P.M., interview with Resident #84 revealed he was in need of an eye exam. The resident stated he had not seen an eye doctor or had new glasses for over 10 years due to the lack of insurance. Resident #84 stated he could see things close up without his glasses for things like reading but could not see anything far away due to being blurry. Resident #84 stated he was looking forward to being able to see things far away again. The resident further stated the facility social services had told him the eye doctor was supposed to be at the facility next month but now the optometrist would not be at the facility for another four months; therefore, social services told him they would contact an eye provider in the community to be seen but she had not gotten back with him regarding an appointment to date. Resident #84 again stated he was looking forward to having new glasses and being able to see things at a distance again. On 04/29/26 at 3:32 P.M., interview with Social Services (SS) #12 verified she did complete a comprehensive vision exam that included the resident's distance vision, and the above MDS assessments on 03/25/26 and 04/07/26 were not accurate. SS #12 also stated she did not evaluate the resident's vision while using his glasses stating he was able to read the admission paperwork and took that to mean he did not have vision concerns. On 04/30/26 at 1:26 P.M., interview with the Director of Nursing verified the above MDS assessment for Resident #38 was not accurate. 2. Medical record review revealed Resident #38 was admitted on [DATE] with diagnoses including senile degeneration of brain, dysphagia, muscle wasting and acute pulmonary insufficiency following nonthoracic surgery. Review of the Hospice Initial Certification dated 04/20/26 revealed Resident #38 was admitted to hospice with a certification of a limited life expectancy of six months or less, if the terminal illness runs its normal course. Review of the significant change MDS assessment dated [DATE] revealed the resident was receiving hospice services but did not have a prognosis of less than six months life expectancy. On 04/30/26 at 1:26 P.M., interview with the Director of Nursing verified the above MDS assessment for Resident #38 was not accurate.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to ensure comprehensive care plans were completed as required. This affected two residents (#5 and #39) of 25 residents reviewed for care plans. The census was 75.Findings include:1. Record review of Resident #39 revealed the resident was admitted on [DATE] with diagnoses including insomnia, dementia, anxiety, constipation, hypertension, depression, gastro esophageal reflux disease, dysphagia, and hypertension. Review of Resident #39 progress note dated 04/13/26 at 6:30 P.M. revealed an order was received for an indwelling urinary catheter. Review of Resident #39 progress note dated 04/14/26 at 11:45 A.M. revealed 900 milliliter (ML) or urine was emptied for the residents indwelling urinary catheter. Review of Resident #39 progress note dated 04/14/26 at 11:59 A.M. revealed the medical director advised staff to leave the residents indwelling urinary catheter in place. Review of Resident #39 progress note dated 04/19/26 at 3:57 P.M. revealed medical director gave orders to remove the residents indwelling urinary catheter. Indwelling urinary catheter removed without difficulty. Review of Resident #39 progress note dated 04/27/26 at 10:30 A.M. the resident had not voided in 12 hours, Resident #39 stated they feel like they need to go but cant. Indwelling urinary catheter inserted with immediate return of 400 ml of urine. Review of Resident #39 progress note dated 04/27/26 at 11:45 A.M. revealed medical director gave orders to leave indwelling urinary catheter in place. Review on 04/27/26, 04/28/26 and 04/29/26 of Resident #39 care plan completed 02/06/26 revealed no documentation of a care plan for an indwelling urinary catheter. Observation on 04/27/26 at 9:33 A.M. of Resident #39 revealed the resident was lying in bed with an indwelling urinary catheter present. Interview on 04/29/26 at 10:18 P.M. with facility Director of Nursing (DON) confirmed Resident #39 did not have a comprehensive care plan for the indwelling urinary catheter care plan until 04/29/26. 2. Medical record review revealed Resident #5 was admitted on [DATE] with diagnoses including chronic pain, unspecified contracture, cerebral infarction, chronic gout, osteoarthritis left shoulder and diabetic neuropathy. Review of the 5-day Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #5 was moderately impaired for daily decision-making, received scheduled and PRN (as needed) pain medications, had complaints of frequent moderate pain that had occasional effects on sleep, activities and day-to-day activities. Review of the Physician Orders dated April 2026 revealed Resident #5 received Diclofenac Sodium (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	External Gel 1 % (nonsteroidal anti-inflammatory drug) to his left shoulder topically four times a day related to chronic pain and Gabapentin (nerve pain)100 milligrams (mg) twice a day for diabetic neuropathy. Review of the medical record revealed no evidence of a pain plan of care for Resident #5. On 04/28/26 at 10:26 A.M., interview with Resident #5 revealed he complained of severe left shoulder pain rating his pain a 10 of 10 on a scale of zero to 10. On 04/30/26 between 2:25 P.M. and 2:32 P.M., interview with the DON confirmed the resident was admitted on [DATE] and did not have a comprehensive plan of care for pain. Review of the policy: Pain Management revised 12/08/25 revealed the facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review and interview, the facility failed to ensure dependent residents received adequate hygiene and showers. This affected one resident (#30) of one resident reviewed for activities of daily living. The census was 75. Findings include:Medical record review revealed Resident #30 was admitted on [DATE] with diagnoses including dementia, gastric ulcer with perforation, dysphagia, severe protein calorie malnutrition, cardiac arrhythmia, cognitive impairment and incontinence. Review of the 5-day admission Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #30 was severely impaired for daily decision-making, was dependent on staff for shower and bathing and required substantial/maximal assistance with personal hygiene. Review of the Kardex revealed Resident #30 was to receive a shower on Tuesday and Friday dayshift. Review of the Task: Bathing/Showers and Shower Refusals dated 04/01/26 to 04/30/26 revealed Resident #30 had received no showers/baths and had no shower refusals during April 2026. Review of the 400 Hall Shower Schedule undated revealed Resident #30 was to receive showers on Tuesday and Fridays. Review of the care plan: Impaired ADL Function: Resident had impaired decision-making ability, impaired memory, required assist to perform/ complete ADL care due to diagnoses dated 04/10/26 and revised on 04/19/26 revealed interventions included to set up and place self-care equipment within easy reach of resident for morning, evening and bedtime care, provide assistance with bath/shower, explain care before giving, and promote independence and self-performance by segmenting tasks, providing verbal cues, demonstration, and/or step-by-step instructions. On 04/27/26 at 2:08 P.M., observation revealed Resident #30 had facial hair stubble noted, his hair was uncombed and greasy and a body odor was noted. The resident was also observed spitting food from his mouth that was observed on his shirt sleeve and floor next to his wheelchair. The resident stated he needed staff to help him with his activities of daily living. On 04/29/26 at 11:43 A.M., interview with Certified Nurse Aide (CNA) #106 revealed shower schedules were posted to inform staff of what residents receive a shower on which days. CNA #106 stated all documentation of baths and showers was to be documented in the computer after the care was provided or at least on the same day. All care was documented in the computer documentation system. On 04/30/26 at 4:46 P.M., interview with the Director of Nursing (DON) verified there was no documented evidence of Resident #30 receiving any showers or baths during the month of April 2026. The DON verified all showers were to be documented in the electronic medical record, she had spoken to staff who stated he had received showers; however, there were none documented. The DON verified any resident could have showers/baths on non-shower days if needed.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records, review of activity logs and calendars, and interviews with staff and residents, the facility failed to provide activities to meet the needs and interest for Resident #3 and Resident #84. This affected two residents (Resident #3 and Resident #84) of two residents reviewed for activities. The facility census was 75.Findings include: 1.Review of the medical record for Resident #3 revealed admission to the facility on [DATE] and a re-admission on [DATE] with diagnoses including subdural hemorrhage (brain bleed), stroke affecting right dominant side, macular degeneration (progressive disease of the eye leading to blindness), hearing loss, constipation, depression, and high blood pressure. Review of the annual Minimum Data Set (MDS) 3.0 comprehensive assessment completed on 10/07/25 for Resident #3 revealed a brief interview for mental status score of 15/15 indicating no cognitive impairment. Further review of the MDS revealed that Resident #3 was hard of hearing and had impaired vision. Review of the activity log for April 2026 and March 2026 for Resident #3 revealed active participation for walking/wheeling, listening to radio/television, and news/current events. Further review revealed refusal for bingo, coffee, group discussion, religious services/studies, cards, arts and crafts, and social parties. Review of Resident #3 care plan revealed the resident would have one on one (1:1) visits by staff if not attending group activities. Review of the 1:1 activity logbook revealed no evidence of Resident #3 needing 1:1 visit or staff providing 1:1 visit. Resident #3's care plan and 1:1 activity binder lacked evidence of 1:1 visits. Observation and interview on 04/27/26 at 9:24 A.M. of Resident #3 revealed her sitting in her wheelchair dressed and groomed and looking out window. There was purple device with headphones attached sitting on the bed. Resident #3 was very hard of hearing and required increased volume of a person speaking and repetition of words to understand the person speaking. Resident #3 reported she is very hard of hearing and practically blind. Resident #3 reported the purple device was an audio book she listens to. Observation on 04/28/26 at 1:19 P.M. revealed Resident #3 in her room sitting in wheelchair alone with headphones on and using the purple device. Observation on 04/28/26 at 3:00 P.M. revealed Resident #3 alone in her room with door almost completely shut. Observation and interview on 04/29/26 at 11:20 with Resident #3 revealed resident with headphones on and listening to her audio book. Resident #3 reported that her niece brings her the audio book from home and she gets sent a new one every month from Cleveland Library. Further interview with Resident #3 revealed she gets bored during the day and only has her audio books to keep her occupied. Resident #3 reported she does not attend group activities because she cannot see or hear what is going on and does not want to be a bother to the group. Resident #3 reports she tried bingo but the numbers just were large enough and she couldn't hear the numbers (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	being called. Resident #3 reports prior to her vision and hearing worsening she liked to garden was in a gardening club and enjoyed playing card games. Resident #3 also reported she liked attending her home church as well. Resident #3 reports the staff drop of the daily chronicle but she cannot read it and sometimes when her niece comes she will read it to her. Resident #3 reports her nieces do take her out into the gazebo in the evenings if the weather is nice, but staff have not offered to do this. Interview on 04/29/26 at 4:46 P.M. with CNA #124 (the prior interim activities director) revealed that activity staff are to provide the daily chronicle (news sheet) to each resident daily and if the resident needs assistance they are to read the paper to the residents. CNA #124 denies ever reading the chronicle to Resident #3 when she passed them out. CNA #124 also reports that one-on-one room visits are to be 15-20 minutes. CNA #124 reported that Resident #3 mostly stayed in her room but denied knowing asking her why or addressing any concerns related to her hearing and vision. Interview on 04/29/26 at 3:56 P.M. with the Activities Director (AD) #832 revealed she has only been working at the facility for three weeks; but has 10 years of experience related to activities programs. AD #832 admitted she did not know all the residents' interest or needs yet and was still relying on her staff for information and direction. AD #832 reports that 1:1 room visits should be 15-20 minutes. AD #832 reported there was not specific activities for hearing impaired or residents with significant visual deficits, but she would be starting a new sensory activity weekly in May to engage those residents as well. 2. Medical record review revealed Resident #84 was admitted on [DATE] with diagnoses including hypertension, acute respiratory failure with hypoxia, abnormalities of gait and mobility, acute myocardial infarction, ventricular tachycardia and fibrillation, hypotension, cerebral infarction and exacerbation of chronic obstructive pulmonary disease. Review of the admission Activity Interview For Daily and Activity Preferences (3.0) assessment dated [DATE] revealed Activity Preferences included it was not very important for the resident to: listen to music he liked, have books/newspapers/magazines to read, be around animals or do things in a group. It was very important for the resident to: keep up with the news, do his favorite activities and go outside when the weather was good. Review of the Little or No Involvement in Activities care plan dated 03/23/26 revealed the resident enjoyed fishing, being outdoors, watching and playing sports and crossword puzzles. The resident was to be provided one-on-one activities. Review of the admission Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #84 was cognitively intact for daily decision-making and activities included it was not very important to have books, newspapers, and magazines to read but was very important to do his favorite activities. Review of the Individual Resident Daily Participation Record 03/19/26 through 03/31/26 revealed no evidence of interest in crossword puzzles. Review of the medical record revealed no evidence of one-on-one activities provided to Resident #84 between 03/19/26 and 04/29/26. On 04/27/26 at 3:43 P.M., interview with Resident #84 stated staff gives him a daily list of activities but they don't stay. Resident #84 stated he likes bingo but hasn't gone to any due to he had not been (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	feeling well. Resident #84 stated he had hoped to start attending soon. He liked to read magazines and complete crossword puzzles to keep his mind sharp. Resident #84 stated he would have to have his daughter bring him in some, as the facility had not provided him. On 04/29/26 at 4:19 P. M. interview with Activity Director #310 stated she had been in this role for about three weeks and had been reviewing and individualizing resident activities including care plans and the activities being offered; however, she had not reviewed Resident #84's activity care plan or assessment yet. Activity Director #310 stated there were crossword puzzles available and these should have been provided since it was an identified interest. Activity Director #310 also verified Resident #84 was care planned to have one-on-one activity visits which would be provided in 15 to 20 minute time sessions. Activity Director #310 verified there was no evidence Resident #84 had received any one-on-one activities as indicated in his care plan. On 04/29/26 at 4:53 P.M., interview with CNA #124 revealed if the resident stays in their rooms and don't get out of the room, they often were provided one-on-one activities.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, contract review, policy review and interview, the facility failed to ensure vision services were provided as needed. This affected one resident (#84) of one resident sampled for communication. The census was 75. Findings include: Medical record review revealed Resident #84 was admitted on [DATE] with diagnoses including hypertension, acute respiratory failure with hypoxia, abnormalities of gait and mobility, acute myocardial infarction, ventricular tachycardia and fibrillation, hypotension, cerebral infarction and exacerbation of chronic obstructive pulmonary disease. Review of the admission Minimum Data Set 3.0 (MDS) assessment dated [DATE] and the 5-day MDS assessment dated [DATE] revealed Resident #84 was cognitively intact for daily decision-making and had adequate vision with the use of corrective lenses. Review of the Order Summary Report dated 03/19/26 revealed Resident #84 may have ancillary services including optometry evaluations and treatment as indicated. Review of the medical record revealed Resident #84's undated Baseline Care Plan indicated the resident had adequate vision. The Social Service section of the baseline care plan was blank for social services provided, mental health needs behavioral concerns, pre-admission screening, social service goals and depression screening. Review of the vision Final Appointment Listing dated 04/09/26 revealed the most recent optometrist visit was on 04/09/26 and 13 residents had been scheduled to be seen while at the facility. There was no evidence Resident #84 was on the list to be seen or was evaluated by the optometrist on 04/09/26. On 04/27/26 at 3:53 P.M., interview with Resident #84 revealed he was in need of an eye exam. The resident stated he had not seen an eye doctor since being at the facility and it had been over 10 years since having an eye exam or new glasses. Resident #84 stated he could see things close up for reading without his glasses but could not see anything far away even with his glasses. Resident #84 stated it had been over 10 years since he had seen an optometrist or had new glasses due to the lack of insurance. Resident #84 stated he was looking forward to being able to see things far away again. The resident further stated the facility social services had told him the eye doctor was supposed to be at the facility next month but now the optometrist would not be at the facility for another four months; therefore, social services told him they would contact an eye provider in the community to be seen but she had not gotten back with him regarding an appointment to date. Resident #84 again stated he was looking forward to having new glasses and being able to see things at a distance again. On 04/27/26 at the time of the above interview, Resident #84 was observed picking up a pair of black framed glasses that were on his overbed table and put them on. The resident stated he could not see at a distance through these lenses and they were his only pair. On 04/29/26 at 3:32 P.M., interview with Social Services (SS) #12 revealed the optometrist evaluated residents at the facility on 04/09/26. SS #12 verified Resident #84 was not seen by the optometrist because he was a short-term resident and he did not have any vision concerns. SS #12 stated she completed the comprehensive MDS assessment for Resident #84's vision, the resident was able to read his admission paperwork during the sign-in process and that was how she determined his vision was adequate. SS#12 could not remember if he was wearing his glasses at the time, did not test his distance vision or ask the resident if he had any visual problems. SS #12 stated she does not review the need for ancillary services or review consents with short-term residents because they would just follow-up with their own provider once discharged back to the community. SS#12 stated she was unaware he had not had new glasses for 10 years or had any concerns with distance vision, did not accurately complete the comprehensive vision assessment, did not obtain consents for ancillary services and the resident could have seen the optometrist earlier in the month if she had known. SS #12 stated she would have to find an optometrist in the community to evaluate Resident #84 as the facility optometrist was not due to return to the facility for approximately six months.Review of the vision contract: Facility Services Agreement dated 07/22/17 revealed the facility had a contract with (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an external provider for ancillary services including optometry services. For arrangements described in Section 1861 (w) of the Social Security Act, the facility shall continue to assume responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such facility; and the timeliness of the services. Optometry services provided included vision examinations, medical eye evaluations, and fitting/ordering glasses.Review of the policy: Hearing and Vision Services revised 12/08/25 revealed the facility was to ensure all residents have access to hearing and vision services and receive adaptive equipment as needed. The facility will utilize the comprehensive assessment process for identifying and assessing a resident's vision and hearing abilities in order to provide person-centered care. This process includes: obtaining history from medical records, family and resident regarding hearing and vision abilities; MDS and care area assessments; ongoing monitoring of sensory problems; care plan development, implementation and evaluation.

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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 interview, record review, and policy review the facility failed to ensure a resident's incontinence brief was applied correctly resulting in the development of a pressure injury. This affected one resident (#74) of four residents reviewed for skin impairments. The census was 75.Findings include: Record review revealed Resident #74 was admitted to the facility on [DATE] with diagnoses including pulmonary hypertension, type two diabetes, chronic obstructive pulmonary disease, Stage 4 chronic kidney disease, insomnia, bradycardia, and atrial fibrillation. Review of Resident #74's care plan dated 12/08/23 revealed the resident was at risk for impaired skin integrity related to easily bruising, incontinence, reduced bed mobility, and thin fragile skin. Goals include the resident will not develop any areas of pressure-related breakdown and the residents' skin integrity will remain intact. Interventions included applying cushions to wheelchair, assist resident with turning and repositioning on routine rounds and as needed, assist with toileting needs and incontinence care on routine rounds and as needed, assist as needed with toileting hygiene and with wearing and changing incontinence undergarments.Review of Resident #74's quarterly minimum data set (MDS) assessment completed 02/21/26 revealed a brief interview for mental status score of 15. Resident #74 exhibited no behaviors and required max assist for toileting, showering and bathing, lower body dressing, and moderate assistance for personal hygiene, footwear and upper body dressing. Resident #74 required maximal assistance for transfers and mobility. The resident was frequently incontinent of bowel and bladder. The resident was at risk of developing pressure ulcers/injuries, the resident was to have a pressure-reducing device for chair, pressure reducing device for bed, and applications of ointments.Review of Resident #74's Braden scale score dated 04/08/26 revealed a score of 16 indicating the resident was at risk for developing pressure ulcers/injuries suggesting a need for preventative interventions, including regular repositioning, moisturizing, and specialized support surfaces to maintain skin integrity.Review of Resident #74's medical record revealed an order placed on 04/14/26 at 3:00 P.M. by the Medical Director to cleanse right proximal posterior thigh with normal saline, pat dry, apply Medi honey to wound bed, cover with dry dressing, change day shift every Tuesday, Thursday, and Saturday for wound care and as needed until healed. This order was discontinued on 04/28/26.Review of Resident #74's progress note dated 04/14/26 at 3:12 P.M. revealed the resident had a new skin issue on the right gluteal fold, pressure ulcer/ injury. This was identified as a new wound. The progress note identified the area as an unstageable pressure injury presenting as deep tissue injury. The wound was acquired in house. The resident had a new wound noted to her right proximal posterior thigh (right gluteal crease region) from depends (incontinence brief). A new intervention was put in place to not pull a brief t0o tight when fastening, leave loose from skin.Review of the wound care nurse practitioner (NP) progress note dated 04/14/26 revealed Resident #74 had a new pressure, suspected deep tissue injury (SDTI) on their right posterior thigh, measuring 1.8 centimeter (cm) in length, 0.9 cm in width, and 0.1cm in depth. The wound had 20% purple epithelium, 80% dermis, and unable to determine (UTD) true depth. Due to co-morbidities that affect healing, the resident remains at risk for wound complications and impaired healing. Without proper wound management, the resident could have further tissue destruction, which could lead to secondary infection, need for surgical debridement, and increased morbidity. Will continue to evaluate weekly and modify the plan of care as medically necessaryReview of Resident #74's wound observation evaluation completed on 04/14/26 revealed a new in-house acquired pressure, suspected deep tissue injury, with 20% purple epithelium, 80% dermis. The wound measured 1.8 cm in length, 0.9 cm in width, and 0.1 cm in depth.Review of Resident #74's medication administration record and treatment administration record revealed no evidence the resident's wound care was provided as ordered by the Medical Director on 04/14/26. Review of wound care nurse practitioner (NP) progress note dated 04/21/26 revealed Resident #74's right lower extremity thigh unstageable pressure (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	measured 0.8 cm in length, 0.3 cm in width, and 0.1 cm in depth. Resident #74 had an excisional debridement of tissue. Post debridement, the wound measurement 0.6 cm in length, 0.3 cm in width, and 0.2 cm in depth with minimal bleeding. The wound status was noted as improved and healing.Review of facility wound observation evaluation completed 04/21/26 revealed Resident #74's right proximal posterior thigh had granulation tissue present, slough tissue present, 20% granulation, 80% slough, scant serous drainage, 0.8 cm in length, 0.3 cm in width, and 0.1 cm in depth.Review of wound care nurse practitioner (NP) progress note dated 04/28/26 revealed Resident #74's right lower extremity thigh was in house acquired pressure that currently measured 0 cm in length, width, and depth. The resident's wound condition was closed, healed.Interview on 04/30/26 at 7:53 A.M. with Resident #74 revealed about two weeks prior she had a wound on her thigh. They think it was because her brief was too tight maybe.Interview on 04/30/26 at 9:50 A.M. with certified nurse aide (CAN) #911 confirmed Resident #74 had an open area on the back of her right thigh, they thought it was from her brief due to the location and how it looked.Interview on 04/30/26 at 2:46 P.M. with Licensed Practical Nurse (LPN) #52 revealed she does all wound care at the facility. The facility has a steady wound care Nurse Practitioner (NP) that comes every Tuesday and she can be consulted via Doximity (private tele health, video consultation). Resident #74 had a wound on her proximal posterior right thigh, almost to the gluteal crease. Resident #74 did not have the wound when she came back from the hospital. LPN #52 believed it was a certified nurse's aide (CNA) that notified her of the presence of the wound but cannot recall who. The wound care NP evaluated Resident #74 initially on 04/14/26 and stated the wound had purple epithelium with scant serous drainage and was opened a little. LPN #52 stated they [staff and the wound care nurse practitioner] believed the wound was from the resident's incontinence brief being pulled too tight, possibly due to its location, not a normal pressure area. LPN #52 stated in a way that the wound would have been avoidable if the brief wasn't put on too tight, Resident #74 also gets pulled up a lot in bed so, that could have made it worse. LPN #52 stated Resident #74 was incontinent and had loose bowels, and frequent problems with moisture associated skin damage (MASD). She had a low air loss mattress and protective cream prior to 04/14/26 in place. She was getting weekly skin checks. Resident #74 was sent to the hospital on [DATE] and returned on 04/01/26. Skin checks dated 04/01/26 revealed Resident #74 had right and left shin discoloration upon return from the hospital, and MASD on the left gluteal cleft, no area noted on the right posterior proximal thigh upon return from the hospital. On 04/07/26 she had her weekly skin check and had a yeast appearing rash to her peri area, and discoloration to her lower legs, no other areas were noted, no areas on the right posterior thigh. LPN #52 stated Resident #74's wound on her right posterior proximal thigh was healed as of 04/28/26, and was there for about two weeks.Review of facility policy titled Pressure Injury Prevention and Management (revised 12/08/25) revealed the facility is committed to the prevention of avoidable pressure injuries. Avoidable means that the resident developed a pressure ulcer/ injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors, define and implement interventions that are consistent.

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	366052	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gables Care Center	351 Lahm Drive Hopedale, OH 43976

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, infection control log review and interview, the facility failed to ensure residents were treated for urinary tract infections as ordered. This affected one resident (#78) of two residents reviewed for urinary tract infections. The census was 75.Findings include:Medical record review revealed Resident #78 was admitted on [DATE] with diagnoses including late onset Alzheimer's disease, chronic kidney disease stage 3, diabetes mellitus, incontinence and urinary tract infections. Review of the Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #78 was severely impaired for daily decision-making, was frequently incontinent of urine and had no urinary tract infections in the previous 30 days. Review of the Health Status Notes revealed on 04/03/26 Resident #78 was seen sitting on her buttocks in the doorway of another resident's room. Staff had observed the resident hit the side of her head on the doorway and slide to the floor. The resident was sent to the emergency room for evaluation. The resident returned to the facility from the emergency room (ER) the same day and had been diagnosed with a UTI and antibiotic orders were received. Review of the Urine Culture dated 04/03/26 revealed Resident #78 urine had greater than 100,000 heavy colony count of the bacteria escherichia coli (e-coli). Review of the ER Patient Visit Information dated 04/03/26 included instructions to administer Cephalexin (antibiotic) 500 milligrams (mg) twice a day for a total of 10 doses. Further review of the Discharge Summary revealed instructions to use this medication as ordered and follow the instructions closely. Review of the electronic Medication Administration Record dated April 2026 revealed Resident #78 was administered eight doses of Cephalexin 500 mg between 04/04/26 and 04/07/26. There was no evidence the resident received the last two ordered doses of Cephalexin. On 04/30/26 at 3:30 P.M., interview with the Director of Nursing (DON) verified Resident #78 was evaluated at the ER and diagnosed with a UTI, was ordered to receive 10 doses of Cephalexin 500 mg, and the order was not completed as written. The DON stated when the order was entered into the electronic physician order it defaulted to the following day which resulted in a transcription error for only eight doses to be administered instead of 10 doses of Cephalexin.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, policy review and interview, the facility failed to provide adequate care and services to manage Resident #5's pain. This affected one resident (#5) of one sampled for pain management. The census was 75. Findings include: Medical record review revealed Resident #5 was admitted on [DATE] with diagnoses including chronic pain, unspecified contracture, cerebral infarction, chronic gout, osteoarthritis left shoulder and diabetic neuropathy. Review of the 5-day Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #5 was moderately impaired for daily decision-making, received scheduled and PRN (as needed) pain medications, the resident had complaints of frequent, moderate pain that had occasional effects on sleep, activities and day-to-day activities. Review of the medical record revealed Resident #5 was hospitalized for congestive heart failure on 04/24/26 and returned to the facility on [DATE]. Review of the Clinical admission Progress Notes dated 04/26/26 revealed Resident #5's pain was rated a five out of 10 to the left anterior shoulder. The resident's pain was described as constant, aching, worse with movement, and non-medication interventions did not provide relief. The progress note indicated the resident was administered PRN medication; however, there was no documented evidence any PRN medications were administered on 04/26/26. Review of the Order Summary Report dated 04/26/26 revealed Resident #5 was ordered Diclofenac Sodium External Gel 1 % (nonsteroidal anti-inflammatory drug) to his left shoulder topically four times a day related to chronic pain and Gabapentin (nerve pain) 100 milligrams (mg) twice a day for diabetic neuropathy. Review of the OT (occupational therapy) Evaluation & Plan of Treatment dated 04/28/26 revealed the resident's left upper extremity strength was not tested due to severe pain. Review of the Skilled Evaluation dated 04/30/26 at 11:05 A.M. revealed Resident #5's pain was unchanged and rated a five out of 10 to the left anterior shoulder. The resident's pain was described as constant, aching, worse with movement, and non-medication interventions did not provide relief. The progress note indicated the resident was administered PRN medication; however, there was no documented evidence any PRN medications were administered at the time of the progress note. Review of the electronic Medication Administration Record dated April 2026 revealed Resident #5 had complaints of pain on 04/27/26: Pain rated five out of 10 at 12:00 A.M. and 6:00 A.M., four out of 10 at 12:00 P.M. and 6:00 P.M On 04/28/26: Pain rated five out of 10 at 12:00 A.M. and 6:00 A.M. The order was then changed to only document once a shift and not to document the resident's pain level at the time of the scheduled administration of diclofenac 1%. There was no evidence the resident had received any PRN pain medications between 04/26/26 and 04/30/26. Review of the medical record revealed no evidence Resident #5 had a comprehensive pain care plan. On 04/28/26 at 10:26 A.M., interview with Resident #5 revealed complaints of severe left shoulder pain a 10 of 10 on a scale of zero to 10. The resident stated he had fallen at home resulting in a dislocated left shoulder and fell again while at the facility that put his shoulder back into place per the physician but nothing seems to alleviate his pain. The resident was unable to state what medications he was receiving for pain, did not want to move his left arm and observed guarding his left shoulder. On 04/30/26 between 2:25 P.M. and 2:32 P.M., interview with the Director of Nursing (DON) verified Resident #5 had complaints of pain that was not responsive to scheduled Diclofenac 1% and did not have any PRN pain medications ordered or administered between 04/26/26 and 04/30/26 despite documentation in skilled charting that PRN medication was administered. The DON also verified Resident #5 did not have a pain care plan in the medical record for review. The DON stated her expectation was residents should have no pain or at least tolerable pain. The record did not indicate what pain level was tolerable for the resident. Review of the policy Pain Management revised 12/08/25 revealed the facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records, staff interviews, and facility policy review, the facility failed to thoroughly address pharmacy recommendations in a timely manner. This affected three residents (#2, #78, and #83) of six residents reviewed for unnecessary medications. The facility census was 75. Findings include: 1.Review of the medical record for Resident #2 revealed admission to the facility on [DATE] with most recent re-entry on 02/26/26 for diagnoses including left above knee amputation, right below the knee amputation, chronic pain syndrome, vascular disease of extremities, high blood pressure, diabetes, heart disease, stage 3 kidney disease, degenerative joint disease of cervical (neck) spine, and carpal tunnel syndrome. Review of the monthly medication review recommendation from the pharmacist for Resident #2 revealed on 03/28/26 a note to the attending provider/prescriber by Consultant Pharmacist #732 noted that based on American Geriatric Society Beers Criteria, Amitriptyline (an anti-depressant) was a potentially inappropriate medication to be used in elderly populations and to please review regimen and monitoring of amitriptyline. Primary Care Physician (PCP) #522 responded on 03/31/26 that Resident #2's Amitriptyline was ordered by psychiatrist and neurologist with no further recommendations provided. The Director of Nursing (DON) signed she noted PCP #522's response on 04/01/26. Further review of the medical record of Resident #2 revealed no evidence that there was notification or follow up to address the pharmacy recommendation regarding the ordered Amitriptyline with Resident #2's psychiatrist or neurologist. Interview on 04/29/26 at 2:12 P.M. with the Director of Nursing (DON) verified that she signed off the pharmacy recommendation on 04/01/26, but confirmed she did not complete any further notification to Resident #2's neurologist or psychiatrist. 2.Record review revealed Resident #83 admitted to the facility on [DATE] with diagnoses including osteoarthritis, acute kidney failure, gastro-esophageal reflux disease, seizures, chronic kidney disease stage 3, and polyneuropathy. Review of Resident #83's current medication orders revealed an order for Pregabalin 100 milligrams (mg) with instructions to give one capsule by mouth two times a day related to type two diabetes mellitus with diabetic neuropathy and an order for Oxycodone-Acetaminophen (an opioid analgesic) 7.5-375 mg with instructions for one tablet by mouth every eight hours as needed for chronic back pain. Review of Resident #83's monthly medication regain review completed between 01/19/26 and 01/20/26 revealed the recommendation referenced the American Geriatrics Society Beers Criteria for potentially clinically important drug-drug interactions that should be avoided in older adults and listed the use of both opioids and Pregabalin. The form noted an increase in the risk of severe sedation-related adverse events including respiratory depression and death and stated to avoid the use, exceptions are when transitioning from opioid therapy to Gabapentin or Pregabalin. The recommendation form asked for the physician to please review the regimen and monitoring of Pregabalin and Oxycodone. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician response to Resident #83's monthly medication regimen review completed between 01/19/26 and 01/20/26 revealed the Medical Director noted on the form that this prescription was monitored by Resident #83's pain specialist. Interview on 04/29/26 at 3:20 P.M. with the DON confirmed Resident #83 has not had an appointment with their pain clinic since admission to the facility, and there is not a scheduled appointment for Resident #83 to visit their pain specialist. Review of the policy: Pain Management revised 12/08/25 revealed the facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences. 3. Medical record review revealed Resident #78 was admitted on [DATE] with diagnoses including Alzheimer's disease with late onset, anxiety, and unspecified depression. Review of the quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #78 was severely impaired for daily decision-making and received medications including antidepressants. Review of the Physician Orders dated April 2026 revealed the resident was receiving the following antidepressants: Remeron (an antidepressant) 15 mg at bedtime, Duloxetine (also known as Cymbalta, an antidepressant) 30 mg twice a day and Escitalopram (also known as Lexapro, an antidepressant) 10 mg daily. Review of the Medication Regimen Review dated 03/26/26 revealed recommendations to review the regimen of Lexapro and Cymbalta due to a major drug interaction due to similarity of pharmacology and the potential for additive adverse effects, including serotonin syndrome, selective serotonin reuptake inhibitors should generally not be administered with serotonin norepinephrine reuptake inhibitors. excessive dose including duplicate therapy. Further review of the pharmacist's recommendation revealed there was no physician/prescriber response. A notation was made by the Director of Nursing (DON) on 03/30/26 stating an outside psychiatric provider managed the above medications for Resident #78. There was no evidence the provider managing the above medications had addressed the pharmacist's recommendations. Review of the psychiatric provider Miscellaneous note dated 04/29/26 at 8:39 A.M. revealed the resident was seen on 04/01/26 and reviewed gradual dose reductions (GDR) were reviewed. No adjustments at this time due to several recent adjustments and will reassess at a later date once adequate time has passed for maximum efficacy of current medication regimen. Goal will be to stop Lexapro if able. There was no evidence that the psychiatric provider addressed the use of Cymbalta and/or the duplicate therapy risks. Review of the electronic Medication Administration Record dated April 2026 revealed Resident #78 received Remeron 15 mg daily, Cymbalta 30 mg twice a day and Lexapro 10 mg daily for unspecified depression. The resident was observed daily for atypical behaviors for the following target behaviors: fearful, restless, irritable, anxious, agitated, pacing, tearful and wandering. The behavioral tracking for April 2026 indicated the resident had behaviors ranging from two behaviors to 15+ behaviors daily; however, there was no evidence of which target behaviors were observed only a quantifying number of behaviors. On 04/30/26 at 1:10 P.M. interview with the DON verified there was no documentation to specify which target behaviors were observed during April 2026. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/29/26 at 5:25 P.M., interview with the DON stated she had not received a response from the psychiatric provider regarding Resident #78's pharmacy recommendation to address the duplicate therapy of Lexapro and Cymbalta. On 04/30/26 at 7:41 A.M., the DON provided a note from the psychiatric provider dated 04/29/26 at 8:39 A.M. The DON stated her expectation for addressing GDR requests would be several days and anything after this would not be considered acceptable. The DON stated the psychiatric provider did not have access to the electronic medical record for a while and would send their recommendations to her and she had not received the response for this resident's GDR recommendation prior to yesterday. The DON reviewed the psychiatric provider note dated 04/29/26 and verified it did not address the duplicate therapy or potential major interactions as requested by the pharmacist for Resident #78. Review of the facility policy titled, Addressing Medication Regimen Review Irregularities, and revised on 12/08/25 revealed the attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, interviews, and facility policy review, the facility failed to ensure suitable and nourishing snack options were available for Resident #1. This affected one (Resident #1) of four residents reviewed for nutrition and hydration. The facility census was 75. Findings include: Review of the medical record for Resident #1 revealed admission the facility on 01/30/25 for diagnoses including osteoarthritis, heart disease, high blood pressure, right knee replacement, dementia-moderate with behavioral disturbances, left knee arthritis, history of viral hepatitis C, depression, and asthma. Further review of the most recent minimum data set (MDS) 3.0 quarterly assessment for Resident #1 dated 04/15/26 revealed a brief interview for mental status score of five, indicating severely impaired cognition. Further review of the MDS revealed Resident #1 required meal set up assistance, used of cane for mobility and had no noted swallowing or dental disorders.Review of the Quarterly Nutrition assessment dated [DATE] revealed the resident was ordered a regular diet with no salt packets and no bread at lunch or dinner. The resident's BMI was listed as 36.4 (indicating the resident was obese). The nutrition note referenced the resident had snacks and candy in her room, attended most food-related activities, and was eating ice cream daily from the ice cream parlor. The note indicating limited snacking was encouraged. Observation and interview on 04/27/26 at 11:33 A.M. with Resident #1 revealed the resident seated in her recliner chair groomed and dressed. Pepsi was present in her room. Resident #1 reported that if the state surveyor came back to bring her a Snickers as she loved them. Follow up observations on 04/28/26 revealed at 2:50 P.M. the resident had a soda can and a bag of regular potato chips present and at 5:17 P.M. revealed Resident #1 seated in her room in her recliner with a package of chocolate chip cookies present. Interview on 04/27/26 at 12:30 P.M. with Resident #1's son revealed he had concerns about the amount of weight his mother had gained since admission to facility. He reported she had gained over 20 pounds. Resident #1's son further reported that his mother had a sweet tooth and would eat only Snickers candy bars and Pepsi if available. Resident #1's son also reported that his mother with hoard snacks in her room. Resident #1's son continued to voice concern that his mother has arthritis in her knees as well as an artificial hip and knee and excess weight is hard on her. The son also reported that he has requested at quarterly meetings that the facility not offer snacks all the time but was told the facility cannot do that. Observation on 04/29/26 at 10:35 A.M. of the snack pass cart revealed the following snacks available on the cart: fudge round cookies, oatmeal cookies, pretzels, Chex mix, plain potato chips, ice cream, root beer, sweet tea, lemonade, coffee, cola, ginger ale, [NAME] buddy bars, nutri-grain bars, fig bars, and hot chocolate. There were no fruits, Jello, sugar free products, or cottage cheese snacks. This was verified by Staff #864 who was providing the snack pass on the 100 hall.Interview on 04/30/26 at 12:16 P.M. with Registered Dietary Technician (RDT) #256 revealed nutritious snacks would include items such as Jello, fruits, cottage cheese. After reviewing the list of snack cart contents from observation on 04/29/26 RDT #256 confirmed that the items provided during the 10:30 A.M. snack pass would not be considered nutrient dense and low-calorie options. RDT #256 further reported that snack carts are supposed to offer fruits in addition to the other items provided. Review of the facility policy titled, Weight Monitoring, and revised on 12/08/25 revealed nutritional interventions will be identified, implemented, monitored and modified (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on review of infection control reports, review of medical records, and staff interview, the facility failed to perform antibiotic stewardship for Resident #77 when the facility did not confirm a diagnosis of a urinary tract infection (UTI) using diagnostic testing before instituting and continuing antibiotic therapy. This affected one resident (#77) reviewed for antibiotic stewardship. The facility census was 75.Findings include: Review of the medical record for Resident #77 revealed admission to facility on 07/14/24 for diagnoses of severe dementia with psychotic behaviors, depression, anxiety, atrial fibrillation (an irregular heartbeat), high blood pressure, anemia (low blood count), insomnia (in ability to sleep), and moderate -protein calorie malnutrition.Review of the Minimum Data Set (MDS) 3.0 assessment for Resident #77 revealed a quarterly assessment completed on 01/16/26 with a brief interview for mental status score of 14/15 indicating cognitively intact at time of assessment. Further review of the MDS for Resident #77 revealed frequent urinary incontinence and always incontinent of bowel. Resident #77 required partial to moderate hands-on assistance for showering/bathing, dressing upper body, and toileting hygiene. Resident #77 required substantial to maximum assistance with dressing lower body, laying to sitting up in bed, and from sitting to standing. Resident #77 required the use of a wheelchair for mobility.Review of the facility infection log for the month of December 2025 revealed Resident #77 had a diagnosis of a UTI on 12/13/25 and was prescribed an oral antibiotic (Cipro) for 5 days. Further Review of the McGeer's Criteria (accepted national standardized definitions used to identify and monitor infections in long-term care residents primarily for surveillance and infection prevention purposes) infection form on 12/13/25 revealed Resident #77 had two symptoms of new onset of urinary frequency and new onset on increased urinary urgency and did not meet the criteria for indication of a urinary tract infection or require infection surveillance. Review of the medical record for Resident #77 revealed no evidence of a urine specimen or urine culture being ordered or obtained prior to or after treatment with oral antibiotic was started. Interview on 04/30/26 at 10:30 A.M. with Registered Nurse (RN) #80, the facility's designated infection preventionist, revealed she was aware that Resident #77 did not have a urine culture and verified Resident #77 did not meet criteria for a urinary tract infection or infection surveillance. Further interview with RN #80 revealed she recalled notifying the provider that an antibiotic was not indicated and requested a urine culture and the doctor wanted the antibiotic started anyway due to it being a Friday and did not want to have to address concerns over the weekend.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on review of survey result postings, review of the survey results binder, and interviews with residents and staff, the facility failed to provide the most recent survey results to residents. This had the potential to affect all 75 residents. The facility census was 75.Findings include: Interview on 04/27/26 at 2:00 P.M. during the Resident Council meeting revealed residents were unable to locate the facility's annual and complaint survey results and were not aware of the results of the last complaint survey conducted on 02/11/26. This was confirmed collectively by the Resident Council President, Resident #65, who reported he would like to know the results of the survey from February.Observation on 04/27/26 at 2:40 P.M. at the main nurse's station for halls 100, 200, and 300 revealed postings in two black frames on the wall with one reading, Past Survey Results, 2 years located in this frame behind this paper. To access, pull all 4 sides of black frame up and you will be able to remove the past survey results to review, please return to frame when finished. The second frame was above the first reading, Past Survey Results, 1 year located in this frame behind this paper. To access, pull all 4 sides of black frame up and you will be able to remove the past survey results to review, please return to frame when finished. Both frames were positioned on the wall above the level of the countertop and not easily accessible to residents who were wheelchair bound.Further observation revealed the results provided under the 2-year frame were dated 03/03/17, 03/31/16, 12/10/15,10/23/14, and 09/11/14. Review of the results of the 1-year frame revealed results dated 05/31/18. This was confirmed at the time of observation in an interview with Licensed Practical Nurse (LPN) #841. LPN #841 removed the results and reported she would get the most recent updated results added.Review of the survey results binder located in the facility's main conference room revealed survey results dated 12/31/24, 09/11/25, and 11/25/25. Interview on 04/27/26 at 5:06 P.M. with the Director of Nursing (DON) revealed the DON confirmed the survey result binder did not contain survey results for the most recent annual survey completed on 04/12/24 and the most recent complaint survey results from 02/11/26.