

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366073	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Embassy of Swanton		STREET ADDRESS, CITY, STATE, ZIP CODE 214 S Munson Rd Swanton, OH 43558	
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 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 observation, medical record review, staff interview and policy review, the facility failed to ensure monitoring of Legionella control measures were in place. This had the potential to affect all residents. Additionally, the facility failed to wear proper personal protective equipment while caring for a resident in enhanced barrier precautions. This affected one (#67) of one resident reviewed for infection control measures. The facility census was 64. Findings include: 1. Review of the facility Legionella Environmental Assessment Form, dated 02/11/26 revealed interventions to prevent Legionella were specific only to the flushing of the closed Assisted Living unit (ALU) showers and bathrooms. Interview on 06/03/26 at 4:00 P.M. with Director of Maintenance (DOM) #219 confirmed the Legionella Environmental Assessment Form was specific only to the ALU. DOM #219 confirmed he had no Legionella prevention measures listed on the Legionella Environmental Assessment Form that were specific to the nursing home. Review of Environmental Monitoring policy dated 09/2018 revealed Legionella prevention monitoring was to include flushing of hot and cold water in rooms that were vacant for ten or more days. The flushing included the running of hot and cold water for five minutes at a time for five different times to be sure the pipes were clear of standing water. Further review of the Environmental Monitoring policy revealed the Legionella prevention intervention of removing and descaling of shower heads quarterly should be in place. Follow up interview on 06/04/26 at 11:10 A.M. with DOM #219 confirmed there was no documentation of flushing of hot and cold water in empty rooms for five minutes at a time for five different times. Additionally, DOM #219 confirmed he was unable to provide documentation showing shower heads were removed and descaled quarterly. DOM #219 continued to state he was unsure where the Environmental Monitoring policy came from as he had never seen it. Interview on 06/04/26 at 3:25 P.M. with Administrator revealed the policies Environmental Monitoring, Infection Control/Water Systems and Water Safety Plan were developed by the previous administrator and it was assumed the policies were developed and shared with DOM #219. 2. Review of the medical record revealed Resident #67 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, acute respiratory failure, traumatic subdural hemorrhage, aphasia, dysphagia, and tracheostomy. Review of the quarterly Minimum Data Set (MDS) for Resident #67 dated 03/31/26 revealed a Brief Interview of Mental Status (BIMS) score of 00, indicating severe cognitive deficit. The resident had no behaviors. Functional abilities included dependence on others for all activities of daily living (ADL) care. Review of physician orders dated 06/14/25 revealed gloves and gown to be worn when dressing bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting as well as during device care or use of central line, urinary catheter, feeding tube, tracheostomy/ventilator. Review of the revised care plan for Resident #67 dated 04/03/26 revealed enhanced barrier precautions were to be in place. Observation on 06/02/26 at 5:30 A.M. revealed (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Certified Nursing Assistant (CNA) #118 and CNA #180 entered Resident #67's room to provide incontinence care. Gloves were applied; no further personal protective equipment (PPE) was donned. CNA's #118 and #180 continued to cleanse mucous around tracheostomy area, provide incontinence care and reposition Resident #67. Interview on 06/02/26 at 5:35 A.M. with CNA #118 and CNA #180 revealed confirmation neither wore PPE. The Enhanced Barrier Precautions (EBP) signage on the door was reviewed with both CNA #118 and CNA #180, both CNAs stated the EBP sign did not relate to Resident #67, and they were not required to wear PPE when providing care to Resident #67. CNA #180 stated the EBP sign pertained to the roommate of Resident #67, and the roommate was independent in her care. Interview on 06/02/26 at 5:41 A.M. with Licensed Practical Nurse (LPN) #159 revealed Resident #67 was in EBP due to resident having a percutaneous endoscopic gastrostomy (PEG) tube as well as a tracheostomy. LPN #159 confirmed that PPE should be worn when providing care to Resident #67. Review of the policy titled Enhanced Barrier Precautions, dated 07/13/22 revealed EBP refers to the use of gown and gloves during high-contact resident care activities. Further review of the policy revealed high contact areas included dressing, bathing, providing hygiene, and changing briefs. This deficiency represents non-compliance investigated under Complaint Number 2734720.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the medical record review, and staff interview, the facility failed to ensure Minimum Data Set (MDS) assessments were completed accurately. This affected seven (#6, #7, #12, #44, #54, #22 and #46) of 22 records reviewed. The facility census was 64. Findings include: 1. Review of the medical record for Resident #6 revealed an admission date of 05/08/18 with diagnoses of parkinsonism, dementia, and multiple sclerosis. Review of Resident #6's quarterly Minimum Data Set (MDS) assessment, dated 02/15/26, revealed the question Should Brief Interview for Mental Status (BIMS) be conducted? was answered yes. Further review revealed a dash (-) was entered by each question pertaining to the BIMS assessment indicating Resident #6's cognition was not assessed. 2. Review of the medical record for Resident #7 revealed an admission date of 08/03/23 with diagnoses of chronic respiratory failure with hypoxia, dependence on ventilator status, and seizures. Review of the quarterly MDS assessment, dated 01/15/26 revealed Resident #7 had intact cognition. Review of Resident #7's comprehensive annual MDS assessment, dated 04/17/26, revealed the question Should Brief Interview for Mental Status (BIMS) be conducted? was answered with a dash (-). Further review revealed a dash (-) was entered by each question pertaining to the BIMS assessment indicating Resident #7's cognition was not assessed. 3. Review of the medical record for Resident #12 revealed an admission date of 06/26/13 with diagnoses of Alzheimer's disease, neuralgia and parkinsonism. Review of Resident #12's quarterly MDS assessment, dated 02/03/26, revealed the question Should Brief Interview for Mental Status (BIMS) be conducted? was answered yes. Further review revealed a dash (-) was entered by each question pertaining to the BIMS assessment indicating Resident #12's cognition was not assessed. Interview on 06/03/26 at 4:58 P.M. with the Director of Nursing (DON) and Regional Registered Nurse (RRN) #230 revealed the MDS Coordinator worked remotely. 4. Review of Resident #44's medical record revealed an admission date of 11/01/24 with a diagnosis of schizoaffective disorder, congestive heart failure, anemia, dementia, manic episode, and psychosis. Review of Resident #44's annual MDS dated [DATE] revealed section C was failed to be assessed. Interview on 06/04/26 at 9:32 A.M. with the DON confirmed cognition was not assessed in the most recent MDS assessment for Resident #44. 5. Review of the medical record for Resident #54 revealed an admission date of 07/30/25. Diagnoses (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	included anoxic brain injury, dysphagia, hypertension, cerebellar ataxia, and cardiomyopathy. Review of the quarterly MDS assessment dated [DATE] revealed the resident had intact cognition. Review of a significant change MDS assessment dated [DATE] revealed the resident's cognition status was not assessed. Interview on 06/04/26 at 7:59 A.M., RRN #230 verified Resident #54's cognitive assessment was not accurately completed. RRN #230 revealed the Resident Assessment Instrument (RAI) manual guidelines were used to complete resident MDS assessments. Interview on 06/04/26 at approximately 8:30 A.M. with the Administrator confirmed the BIMS assessments were not completed accurately for Resident #6, Resident #7, Resident #12, Resident #44, and Resident #54. 6. Review of the medical record for Resident #22 revealed an admission date of 02/09/26. Diagnoses included end stage renal disease, type two diabetes mellitus, atrial fibrillation, and hypertension. Review of the quarterly MDS assessment dated [DATE] revealed the resident had intact cognition. Further review of the MDS assessment revealed the resident was assessed as not being edentulous (no teeth). Observation on 06/01/26 at 10:42 A.M. of Resident #22 revealed the resident had no teeth. Interview on 06/01/26 at 10:42 A.M., Resident #22 revealed she had no teeth and her old dentures no longer fit. Interview on 06/04/26 at 7:59 A.M., RRN #230 verified the MDS assessment noting the resident was not edentulous was inaccurate as the resident had no teeth. 7. Review of the medical record for Resident #46 revealed an admission date of 02/24/25 with diagnoses of chronic obstructive pulmonary disease, alcoholic cirrhosis of liver, and epilepsy. Review of the annual comprehensive MDS assessment, dated 02/13/26, revealed Resident #46 did not use tobacco. Review of the modified quarterly MDS assessment, dated 03/31/26, revealed Resident #46 had impaired cognition. Review of Resident #46's smoking agreement revealed it was signed by Resident #46 on 02/25/25. Review of the care plan initiated 03/11/25 and revised 11/10/25 revealed Resident #46 had a potential for safety hazard or injury related to smoking. Resident #46 was able to smoke with supervision by staff or family. Review of the undated list of residents who smoke, provided by the facility on 06/01/26, revealed (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #46 was included on the list. Interview on 06/04/26 at 7:58 A.M. with RRN #230 confirmed Resident #46's comprehensive annual MDS assessment, dated 02/13/26, was completed inaccurately in reference to Resident #46's tobacco use.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, record review, staff interview and review of the menu spreadsheet, the facility failed to ensure residents received all components of the meal. This affected all residents in the facility except for 14 (#2, #3, #4, #5, #13, #19, #30, #35, #51, #52, #59, #60, #65, and #67) residents identified to receive no food from the kitchen. The facility census was 64. Findings include:1. Review of the medical record for Resident #6 revealed an admission date of 05/08/18 with diagnoses of Parkinsonism, dementia, and multiple sclerosis.Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/15/26, revealed Resident #6's cognition was not assessed. Resident #6 required partial/moderate assistance for eating.Review of the current physician order dated 04/23/26 revealed Resident #6 was on a mechanical soft diet with thin liquids, with crust to be removed from sandwiches, and cups with lids.2. Review of the medical record for Resident #12 revealed an admission date of 06/26/13 with diagnoses of Alzheimer's disease, neuralgia and Parkinsonism. Review of the quarterly MDS assessment, dated 02/03/26, revealed Resident #12's cognition was not assessed. Further review revealed Resident #12 required supervision or touching assistance for eating.Review of the current diet order, dated 12/17/24, revealed Resident #12 received a pureed diet with thin liquids.3. Review of the medical record for Resident #54 revealed an admission date of 07/30/25 with diagnoses of anoxic brain damage, dysphagia, and cerebellar ataxia.Review of the significant change comprehensive MDS assessment, dated 03/03/26, revealed Resident #54's cognition was not assessed, and he was dependent on staff for eating.Review of the physician order dated 03/24/26 revealed Resident #54 received a minced and moist texture diet. Continuous observations on 06/01/26 from 11:59 A.M. through 12:40 P.M. revealed residents being served the noon meal in the dining room.Observation on 06/01/26 at 12:09 P.M. revealed Resident #12 was served two pureed bowls of food. One bowl contained orange colored food, and one bowl contained beige colored food. Concurrent interview with Activities Recreation Director (ARD) #164, who was providing assistance in the dining room, stated she could not determine what the food items were in Resident #12's bowls.Observation on 06/01/26 at approximately 12:15 P.M. of the posted menu in the dining room revealed the noon meal included a salad, penne pasta with meat sauce, garlic bread and marble cake. Observation on 06/01/26 at approximately 12:17 P.M. revealed Resident #6 eating penne pasta. Resident #6 did not receive a salad or garlic bread. Continued observation revealed Resident #54 received only penne pasta and no salad or garlic bread. Follow-up interview on 06/01/26 at 12:47 P.M. with ARD #164 confirmed residents on a mechanical soft diet, such as Resident #12 and Resident #54, who was on a minced and moist diet, only received the penne pasta with meat sauce and did not receive any other items with the meal, such as a salad or vegetable or garlic bread. ARD #164 further confirmed residents on a pureed diet only received two bowls of food.Interview on 06/01/26 at 2:18 P.M. with the Director of Food Services (DFS) #191 confirmed she did not provide a vegetable or bread substitute for residents on a mechanical soft or minced and moist diet. Further, DFS #191 confirmed she did not provide a vegetable substitute for residents on a pureed diet. Concurrent review of the menu spreadsheet revealed residents on a mechanical soft diet should have received shredded tossed salad and a slice of garlic bread, residents on a minced and moist diet should have received minced and moist marinated green beans and pureed garlic toast, and residents on a pureed diet should have received pureed soft marinated green beans and pureed garlic toast. 4. Interview on 06/03/26 at 11:29 A.M. with [NAME] #189, during preparation for the noon meal, revealed the menu called for chicken breast, sweet potatoes, peas and carrots, and a slice of wheat (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bread. Observations of meal service on 06/03/26 between 11:58 A.M. and 1:02 P.M. revealed no bread was served. Interview on 06/03/26 at 1:08 P.M. with [NAME] #189 confirmed bread could be offered to all residents, regardless of diet order. [NAME] #189 stated the crust would be cut off before it was offered to residents on a mechanical soft diet, and bread would be pureed for residents on a pureed diet. [NAME] #189 confirmed bread was not given to any residents during the noon meal on 06/03/26.		

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to ensure resident funds were reimbursed timely after discharge. This affected two (#77 and #78) of three residents reviewed for fund disbursement. The facility census was 64. Findings include: 1. Review of the medical record revealed Resident #77 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, hypertension, type II diabetes mellitus, lymphedema and major depressive disorder. Resident #77 passed away on 02/02/26 while still admitted to the facility. Review of the funds disbursement check for Resident #77 revealed it was dated 03/30/26. The representative of Resident #77 called the facility after receiving the check and stated it was the wrong refund amount. A second check was disbursed on 04/08/26. Interview on 06/04/26 at 3:00 P.M. with Business office Manager (BOM) #177 revealed upon investigation the first disbursement check amount was incorrect because the representative of Resident #77 came in to the office at the beginning of February and paid the month according to the rate per day in cash and there was no record of the payment. 2. Review of the medical record for Resident #78 revealed an admission date of 03/01/17 with diagnoses of hypertension, seizures, and bipolar disorder. Resident #78 discharged to another long term care facility on 12/03/25. Review of the funds disbursement check for Resident #78 revealed it was dated 02/27/26. Interview on 06/04/26 at 2:08 P.M. with Business Office Manager (BOM) #177 revealed the role of BOM was vacant from approximately the end of December 2025 until she began at the end of January 2026. BOM #177 confirmed Resident #78's funds were not paid out within 30 days due to the vacancy and the process of learning the new role. Review of the undated policy Resident Trust Fund Accounting and Records, revealed the personal needs account must be closed within thirty days of death or discharge. This deficiency represents non-compliance investigated under Complaint Numbers 2808521 and 2727019		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review, staff interview, and policy review the facility failed to provide a resident with a 48 hour notice of non-payment of services. This affected one (#76) of three residents reviewed for beneficiary notices. This had the ability to affect all residents. The facility census was 64. Findings include: Review of Former Resident (FR) #75's medical record revealed an admission date of 12/24/25 and a discharge date of 01/01/26. FR #75 was discharged to home. Diagnoses included acute kidney failure, chronic kidney disease, and type II diabetes mellitus. Review of FR #75's Notice of Medicare Non-Coverage dated 12/31/25 revealed the resident's payment for skilled services would end on 12/31/25. The notice letter of non-coverage was signed on 12/31/25 by the residents' guardian. Interview with the Director of Social Services #104 on 06/04/2026 9:37 A.M. verified FR #75's services ended on the same day the notification was provided. Review of the nursing progress note dated 01/01/26 revealed Resident #75 was discharged to home with his daughter. Review of the undated facility policy titled Advance Beneficiary Notice, revealed to ensure that the resident, or representative, has enough time to make a decision whether or not to receive the services in question and assume financial responsibility, the notice shall be provided at least two days before the end of the Medicare covered Part A stay or when all of Part B therapies are ending. The notices must not be provided while the resident or representative is under duress or in an emergency situation.		

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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, staff interview and policy review, the facility failed to provide adequate and timely oral care to a dependent resident. This affected one (#67) resident out of one reviewed for oral care. The facility census was 64. Findings include: Review of the medical record revealed Resident #67 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, acute respiratory failure, traumatic subdural hemorrhage, aphasia, dysphagia, and tracheostomy. Review of the quarterly Minimum Data Set (MDS) for Resident #67 dated 03/31/26 revealed a Brief Interview of Mental Status (BIMS) score of 00, indicating severe cognitive deficit. No behaviors indicated. Functional abilities included dependence on others for all activities of daily living (ADL) care. Review of revised care plan for Resident #67 dated 04/03/26 revealed staff are to provide oral care every shift and as needed. Review of physician orders entered for Resident #67 on 06/13/25 revealed oral care to be provided every shift and as needed. Observation on 06/02/26 at 5:30 A.M. revealed Certified Nursing Assistant (CNA) #118 and CNA #180 were in with Resident #67 providing incontinence care and repositioning. A white object approximately two inches in length was noted to the right upper lip of Resident #67. CNA #118 felt the object and stated it was skin. CNA #180 voiced to not pull at the object for fear of making Resident #67 bleed. Interview on 06/02/26 at 5:35 A.M. with CNA #118 and CNA #180 revealed because Resident #67 has a tracheostomy, oral care is provided by Respiratory Therapy. Both CNA #118 and CNA #180 verified they did not complete oral care at all during their overnight shift. Interview on 06/02/26 at 5:44 A.M. with Respiratory Therapist (RT) #148 revealed that RT does complete oral care once a shift and as needed. Interview on 06/02/26 at 5:50 A.M. with Registered Nurse (RN) #156 revealed RT provides oral care to residents with a tracheostomy. RN #156 verified she does not provide oral care to residents with a tracheostomy. Interview on 06/02/26 at 6:47 A.M. with the Director of Nursing (DON) revealed RT is assigned to complete oral care once a shift and as needed. CNA's, Licensed Practical Nurses (LPN) and RNs are to complete oral care as needed throughout their shifts. The DON confirmed CNAs, LPNs and RNs are educated on how to provide oral care on residents who have a tracheostomy. Interview on 06/02/26 at 7:45 A.M. with CNA #144 revealed she provides oral care to the outside of the mouth only to residents with a tracheostomy. Interview on 06/02/26 at approximately 1:00 P.M. with Regional Registered Nurse (RRN) #230 revealed CNAs, LPNs and RNs are to complete oral care as needed. RRN #230 continued to state education on oral care to residents with a tracheostomy is provided to all nursing staff upon hire. Review of CNA task documentation with RRN #230 revealed no specific task for completing oral care. Current oral care task states Dependent - helper does all of the effort. Resident does none of the effort to complete the activity or, the assistance of two or more helpers is required for the resident to complete the activity. RRN #230 verified there was no further task documentation noted for oral care. Review of the progress notes for Resident #67 revealed RT completing oral care at least once a shift. No other disciplines documented that oral care was complete. Review of the policy titled Oral Care, dated 2022 revealed it is the practice of the facility to provide oral care to residents in order to prevent and control plaque-associated oral diseases. Review of the undated policy titled Oral Care Procedures for the Dependent Patient, revealed oral care is to be provided every shift, before and after meals as needed. This deficiency represents non-compliance investigated under Complaint Numbers 2734720 and 2727019.		

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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, review of the medical record, and interview, the facility failed to ensure compression stockings were administered per physician orders. This affected one (#50) of two residents reviewed for edema. The facility identified 12 residents with physician orders for compression stockings. The facility census was 64. Findings include: Review of the medical record for Resident #50 revealed an admission date of 05/02/25 and a readmission date of 01/05/26. Diagnoses included metabolic encephalopathy, atrial fibrillation, type two diabetes mellitus, hypertension, and chronic kidney disease stage three. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition. The resident required substantial/maximal assistance for lower body dressing, putting on and taking off footwear and socks. Review of the care plan dated 08/05/25 revealed the resident had an alteration or potential for alteration in cardiac output related to atrial fibrillation, hypertension, and congestive heart failure. One intervention included applying compression stockings as ordered by the physician. Review of a physician order dated 02/20/26 revealed the resident had an order for compression stockings daily (on in the morning and off at bedtime) for bilateral lower extremity edema. Review of the treatment administration record on 06/01/26 at 2:59 P.M. revealed documentation the resident's compression stockings had been administered. Review of the nurses' notes 05/30/26 through 06/01/26 revealed no documentation the resident had refused the compression stockings. Observation on 06/01/26 at 2:59 P.M. of Resident #50 with Licensed Practical Nurse (LPN) #192 revealed the resident had no compression stockings on. The resident had pitting edema to the bilateral lower extremities. Interview on 06/01/26 at 2:59 P.M., LPN #192 verified the resident had no compression stockings on. LPN #192 verified she had incorrectly documented the compression stocking had been administered. Interview on 06/03/26 at 1:17 P.M., Regional Registered Nurse (RRN) #230 revealed the facility had no policy regarding the application of compression stockings.		

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NAME OF PROVIDER OR SUPPLIER Embassy of Swanton		STREET ADDRESS, CITY, STATE, ZIP CODE 214 S Munson Rd Swanton, OH 43558	
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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 review of the medical record, staff interview, resident interview, and policy review, the facility failed to ensure vision services were provided to residents. This affected two (#22, #54) of two residents reviewed for vision services. The facility census was 64. Findings include: 1. Review of the medical record for Resident #22 revealed an admission date of 02/09/26. Diagnoses included end stage renal disease, type two diabetes mellitus, atrial fibrillation, and hypertension. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. Review of the vision care plan dated 02/09/26 revealed the resident was at risk for visual decline and undetected eye diseases related to hypertension, type two diabetes mellitus, aging process, and end stage renal disease. There were no interventions to arrange for vision services. Review of the medical record revealed the resident had no signed admission agreement and no documentation of acceptance or refusal of offered ancillary services upon admission. Further review of the medical record revealed no documentation the resident had received vision services. Review of a physician order dated 02/09/26 revealed orders for ancillary services as needed including an ophthalmology consult and optometrist. Interview on 06/01/26 at 10:46 A.M., Resident #22 revealed she had glasses and needed to see the eye doctor as she was having trouble seeing. Resident #22 revealed she told staff she needed to see the eye doctor shortly after she was admitted to the facility. Interview on 06/02/26 at 9:53 A.M., Social Worker (SW) #104 revealed during the admission process there was a form in the admission packet for residents to elect ancillary services including dental and vision. SW #104 revealed there was no social worker in the facility when Resident #22 was admitted. SW #104 also revealed the resident admitted during a management transition at the facility. SW #104 revealed Resident #22 was not provided with an admission agreement to elect ancillary services. SW #104 verified Resident #22 had not been provided with vision services since admission. 2. Review of the medical record for Resident #54 revealed an admission date of 07/30/25. Diagnoses included anoxic brain injury, dysphagia, hypertension, cerebellar ataxia, and cardiomyopathy. Review of the quarterly MDS assessment dated [DATE] revealed the resident had intact cognition. Review of a physician order dated 07/31/25 revealed orders for ancillary services including vision services. Review of the vision care plan dated 08/19/25 revealed an intervention for staff to arrange eye appointments if increased visual deficits were noted. Review of an ancillary services consent for treatment form dated 11/05/25 revealed the resident had consented to receive vision services. Review of a vision provider note dated 01/19/26 revealed the resident was ordered prescription eyeglasses and had received the eyeglasses sometime in February 2026. Interview on 06/01/26 at 3:18 P.M., Resident #54 revealed he had glasses, but they caused blurry vision. Resident #54 revealed he had not been seen by the eye care provider to fix the glasses. Interview on 06/02/26 at 9:58 A.M., SW #104 verified Resident #54 had reported concerns with his eyeglasses. SW #104 revealed she had emailed the vision provider on 03/25/26 and had not received a response from the provider. SW #104 revealed she had not attempted any further follow-up with the provider and the provider had not further assessed the resident's vision and/or eyeglasses. SW #104 verified the follow up with the vision provider was not timely. Review of the facility policy Ancillary Services, dated 01/01/25, revealed the facility would assist residents in obtaining ancillary services as needed including vision services.		

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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, review of the medical record, interview, and policy review, the facility failed to ensure timely and accurate pressure ulcer wound assessments, failed to ensure wound treatments were completed and accurately documented per physician orders. Additionally, the facility failed to ensure pressure ulcer prevention treatments were in place per physician orders. This affected two (#74, #2) of four residents reviewed for pressure ulcers. The facility identified seven residents with pressure ulcers. The facility census was 64. Findings include: 1. Review of the medical record for Resident #74 revealed an admission date of 01/19/26 and a discharge date of 01/27/26. Diagnoses included acute and chronic respiratory failure with hypoxia, tracheostomy status, gastrostomy status, hypertension, abnormal weight loss, and type two diabetes mellitus. Review of an admission summary progress note dated 01/19/26 at 7:38 P.M. revealed the resident had an existing buttock wound and the dressing was dry and intact. Review of a skin risk assessment completed 01/19/26 revealed the resident was at high risk for skin breakdown. Review of the admission skin assessment dated [DATE] revealed the resident has a pressure ulcer to the coccyx. There was no assessment of the wound, no wound measurements, and the wound was not staged. Review of a physician order dated 01/20/26 revealed to cleanse the coccyx with normal saline, pat dry, apply nystatin cream, apply zinc oxide cream, leave open to air every shift for wound care. Review of the Treatment Administration Record (TAR) dated 01/20/26 revealed the wound treatment had been completed on the 12-hour day shift and 12-hour night shift by two different nurses. Review of a nurse's note dated 01/21/25 at 2:52 P.M. revealed the resident had asked the nurse to check his coccyx due to increased pain. The nurse observed a dressing dated 01/11/25 in place on the resident's coccyx which had not looked like an in-house facility dressing. The nurse removed the old dressing, and redness was observed around the area. The nurse then completed the wound treatment per physician orders. Review of a nurse practitioner wound care progress note dated 01/22/26 at 8:09 A.M. revealed the resident had a fungal rash to the bilateral buttocks and a new wound treatment was initiated. Interview on 06/03/26 at 11:55 A.M., Licensed Practical Nurse (LPN) #168 revealed when she went to complete the resident's wound treatment on 01/21/26, she found the resident had a dressing on his coccyx dated 01/11/26. LPN #168 revealed the area had not appeared infected. LPN #168 revealed she reported the incident to the Director of Nursing at the time. Interview on 06/03/26 at 1:44 P.M., the Director of Nursing (DON) revealed staff should have removed the hospital dressing, assessed, and measured the residents' wound upon admission to the facility then obtained treatment orders. The DON revealed the resident had no pressure ulcers prior to discharge to the hospital. The DON revealed the wound care provider saw the resident on 01/22/26 and noted the area was a fungal infection and not a pressure ulcer. Further interview with the DON revealed the nurses had incorrectly documented completing the resident's wound treatment on 01/20/26. 2. Review of the medical record for Resident #2 revealed an admission date of 05/16/25. Diagnoses included heart failure, anoxic brain injury, and contractures. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was never understood. The resident was dependent on staff for toileting, repositioning, and personal hygiene. The resident was at risk for skin breakdown. Review of the skin integrity care plan dated 05/20/25 revealed an intervention for heel boots per physician orders, and to float heels as tolerated. Review of a physician order dated 05/21/25 revealed an order for heel boots for protection every shift. Review of the TAR on 06/02/26 at 2:22 P.M. revealed Resident #2's heel boots for protection had been documented as in place. Observation on 06/02/26 at 2:22 P.M. during wound care for a stage (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	three pressure ulcer to the coccyx and urinary catheter care for Resident #2 with Licensed Practical Nurse (LPN) #218 and Registered Nurse (RN) #119 revealed the resident had no heel boots in place. The resident's heels were observed resting directly on the mattress. Interview on 06/02/26 at 2:22 P.M., RN #119 verified the resident had no heel boots in place. RN #119 also verified she had incorrectly documented the resident's heel boots were in place. Review of the facility policy Wound Treatment Management, dated 01/08/25 revealed wound treatments would be provided per physician orders. The effectiveness of treatments would be monitored through ongoing assessment of the wound. There were no guidelines on assessing a wound. Review of the facility policy Pressure Injury Prevention Guidelines, dated 10/01/23, revealed interventions would be implemented in accordance with physician orders, including the type of prevention devices to be used and for task the frequency for performing them. The effectiveness of interventions would be monitored through ongoing assessment of the resident's wound. This deficiency represents non-compliance investigated under Complaint Number 2727019.		

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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 observation, review of the medical record, interview, and policy review, the facility failed to ensure an indwelling urinary catheter securement device was in place per physician order. This affected one (#2) of two residents reviewed for urinary catheters. The facility identified 13 residents with urinary catheters. The facility census was 64. Findings include: Review of the medical record for Resident #2 revealed an admission date of 05/16/25. Diagnoses included heart failure, anoxic brain injury, and contractures. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was never understood. The resident was dependent on staff for toileting and personal hygiene. Review of the urinary catheter care plan revealed the resident's indwelling urinary catheter was indicated due to a coccyx wound per hospice. Interventions included to provide catheter care per facility policy and to ensure the catheter tubing was not under the resident's legs. There was no intervention documented for securing the urinary catheter tubing. Review of a physician order dated 05/13/26 revealed the resident had an indwelling urinary catheter. Review of a physician order dated 05/13/26 revealed an order for a catheter securement device, ensure placement and replace as needed. Observation on 06/02/26 at 2:22 P.M. of urinary catheter care for Resident #2 with Licensed Practical Nurse (LPN) #218 and Registered Nurse (RN) #119 revealed the resident had no urinary catheter securement device in place. Interview on 06/02/26 at 2:26 P.M., RN #119 verified the resident had no urinary catheter securement device in place. RN #119 also verified she had inaccurately documented the securement device was in place in the treatment administration record (TAR). Interview on 06/04/26 at 7:49 A.M., the Director of Nursing (DON) verified Resident #2 had an order for a urinary catheter securement device and staff should have made sure the securement device was in place. Review of the facility policy Catheter Care, dated 03/02/22, revealed residents with indwelling catheters would receive appropriate catheter care. Further review of the policy revealed no guidelines for the securement devices.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, interview, and policy review, the facility failed to ensure ongoing communication with the dialysis center. This affected one (#22) of one resident reviewed for dialysis services. The facility identified one resident receiving dialysis services. The facility census was 64. Findings include: Review of the medical record for Resident #22 revealed an admission date of 02/09/26. Diagnoses included end stage renal disease, type two diabetes mellitus, atrial fibrillation, and hypertension. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition and was receiving dialysis services. Review of the care plan dated 02/09/26 revealed the resident had end stage renal disease requiring dialysis treatment. One intervention included for staff to communicate with the dialysis center staff regarding the resident's plan of care, laboratory values, and diet/fluid restriction recommendations. Review of the physician orders dated 02/10/26 revealed the resident attended dialysis three times a week on Monday, Wednesday, and Fridays. Review of a physician order dated 04/28/26 revealed the resident attended dialysis three times a week on Tuesdays, Thursdays, and Saturdays. Review of the dialysis communication forms dated 04/03/26 through 04/30/26 revealed there were no dialysis communication forms for 04/06/26, 04/10/26, 04/13/26, 04/15/26, 04/17/26, 04/20/26, 04/24/26, and 04/27/26. Also, the dialysis communication forms dated 04/08/26, 04/22/26, 04/29/26 revealed no returned communication from the dialysis center. Review of the dialysis communication forms dated 05/02/26 through 05/30/26 revealed there were no dialysis communication forms for 05/16/26, 05/19/26, 05/21/26, and 05/30/26. Review of the dialysis communication forms dated 05/12/26, 05/14/26, 05/26/26, and 05/28/26 revealed no returned communication from the dialysis center. Interview on 06/04/26 at 7:49 A.M., the Director of Nursing (DON) verified Resident #22's missing dialysis communication forms and the communication forms lacking documentation of a response to treatment from the dialysis center. Review of the facility policy Dialysis Care, last revised 01/2016, revealed there would be a source of communication between the facility and the dialysis unit with each visit and staff would utilize the dialysis communication form. Further review of the policy revealed that in the event the dialysis unit refused and/or failed to provide communication with the resident visit, staff would document in the clinical record, the dialysis unit had not provided any communication on the communication form provided.		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interview, resident interview, and policy review, the facility failed to ensure dental services were provided to residents. This affected two (#22, #54) of three residents reviewed for dental services. The facility census was 64. Findings include:1. Review of the medical record for Resident #22 revealed an admission date of 02/09/26. Diagnoses included end stage renal disease, type two diabetes mellitus, atrial fibrillation, and hypertension.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. Review of the dental care plan dated 02/10/26 revealed an intervention for staff to arrange for periodic dental consults and follow up visits by dentistry as scheduled and as needed. Review of the medical record revealed the resident had no signed admission agreement and no documentation of acceptance or refusal of offered ancillary services upon admission. Further review of the medical record revealed no documentation the resident had received dental services. Review of a physician order dated 02/10/26 revealed orders for a dental consult as needed. Interview on 06/01/26 at 10:42 A.M., Resident #22 revealed she had no teeth and her old dentures no longer fit. Resident #22 revealed she told staff she needed to see a dentist shortly after she was admitted to the facility.Interview on 06/02/26 at 9:53 A.M., Social Worker (SW) #104 revealed during the admission process there was a form in the admission packet for residents to elect ancillary services including dental and vision. SW #104 revealed there was no social worker in the facility when Resident #22 was admitted . SW #104 also revealed the resident admitted during a management transition at the facility. SW #104 revealed Resident #22 was not provided an admission agreement to elect ancillary services. SW #104 verified Resident #22 had not been provided dental services since admission. 2. Review of the medical record for Resident #54 revealed an admission date of 07/30/25. Diagnoses included anoxic brain injury, dysphagia, hypertension, cerebellar ataxia, and cardiomyopathy. Review of the quarterly MDS assessment dated [DATE] revealed the resident had intact cognition. Review of a physician order dated 07/31/25 revealed orders for ancillary services including dental services. Review of the dental care plan dated 08/19/25 revealed an intervention for staff to arrange for periodic dental consults. Review of an ancillary services consent for treatment form dated 11/05/25 revealed the resident had consented to receive dental services. Interview on 06/01/26 at 3:18 P.M., Resident #54 revealed he had not been provided dental services in the last eight months. Interview on 06/02/26 at 9:58 A.M., SW #104 verified Resident #54 had not been provided routine dental services. Review of the facility policy Ancillary Services, dated 01/01/25, revealed the facility would assist residents in obtaining routine and emergency ancillary services as needed including routine and emergency dental services.		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observation, record review and staff interview, the facility failed to ensure adaptive equipment was provided to residents during meals. This affected two (#6 and #12) residents observed during meal service. The facility identified five (#6, #12, #20, #31, and #49) residents used assistive devices with meals. The facility census was 64. Findings include:1. Review of the medical record for Resident #6 revealed an admission date of 05/08/18 with diagnoses of parkinsonism, dementia, and multiple sclerosis.Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/15/26, revealed Resident #6's cognition was not assessed. Resident #6 required partial/moderate assistance for eating.Review of the current physician order dated 04/23/26 revealed Resident #6 was on a mechanical soft diet with thin liquids, with crust to be removed from sandwiches, and cups with lids.Review of the current physician order dated 04/24/25 revealed Resident #6 should be provided built-up utensils and scoop dish/individual bowls as needed for all meals.Review of the care plan initiated 12/18/18, and updated 05/13/26, revealed Resident #6 was at risk for alteration in nutrition and/or hydration related to history of aspiration or potential for aspiration, type II diabetes mellitus, dysphagia, hypertension, Parkinson's disease, dementia, assistance with meals, use of adaptive equipment, tremors, vitamin deficiency, therapeutic/mechanically altered diet. Interventions included to provide adaptive equipment as ordered (02/15/23).Continuous observations on 06/01/26 from 11:59 A.M. through 12:40 P.M. revealed residents being served the noon meal in the dining room.Observation on 06/01/26 at approximately 12:17 P.M. revealed Resident #6's arm shook as she used a standard fork to feed herself penne pasta. Resident #6 had an uncovered glass of red beverage. Interview on 06/01/26 at 12:21 P.M. with Activities Recreation Director (ARD) #164 and concurrent review of Resident #6's physician orders, confirmed Resident #6 should have cups with lids, should have built up utensils, and should have food in individual bowls or on a scoop plate. Further interview and concurrent observation of Resident #6 confirmed the drink was uncovered, her meal came on a standard plate and standard utensils were provided. Observation on 06/02/26 at 7:22 A.M. revealed residents gathered in the dining room for the breakfast meal. Observation on 06/02/26 at 7:24 A.M. and concurrent interview with Director of Rehabilitation (DOR) #195 of Resident #6 confirmed Resident #6 received breakfast food in bowls with a covered cup, and regular utensils. Concurrent review of Resident #6's physician orders with DOR #195 confirmed Resident #6 should have built-up utensils with meals. DOR #195 proceeded to the kitchen to request built-up utensils.Observation on 06/02/26 at 7:28 A.M. revealed Certified Nursing Assistant (CNA) #172 provided a built-up spoon to Resident #6 and Resident #6 said the hot cereal was too hot. Further observation revealed CNA #172 handed Resident #6 a standard fork and offered eggs. Continued observation revealed DOR #195 returned to Resident #6 with foam grips that slipped onto standard utensils and Resident #6 said I remember these.2. Review of the medical record for Resident #12 revealed an admission date of 06/26/13 with diagnoses of Alzheimer's disease, neuralgia and parkinsonism. Review of the quarterly MDS assessment, dated 02/03/26, revealed Resident #12's cognition was not assessed. Further review revealed Resident #12 required supervision or touching assistance for eating.Review of the care plan, initiated 09/12/22, revealed Resident #12 had an alternation in nutrition and/or hydration related to dementia/Alzheimer's disease, chronic kidney disease stage 3, congestive heart failure, hypertension, Parkinson's disease, feeding dependent, under hospice care, mechanically altered diet. Resident #12 used adaptive equipment at meals due to tremors. Interventions included to provide adaptive equipment as ordered (02/15/23).Review of the (continued on next page)		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician order, initiated 03/23/24 and discontinued 06/02/26, revealed Resident #12 should use a sippy cup with meals and snacks every shift to prevent spilling on herself. Review of the current diet order, dated 12/17/24, revealed Resident #12 received a pureed diet with thin liquids. Continuous observations on 06/01/26 from 11:59 A.M. through 12:40 P.M. revealed residents being served the noon meal in the dining room. Observation on 06/01/26 at 12:38 P.M. revealed CNA #137 sitting next to Resident #12 and attempting to assist Resident #12 with eating. Resident #12 had two bowls of pureed food and an uncovered cup of chocolate milk. Concurrent interview with CNA #137 and review of Resident #12's physician orders revealed Resident #12 should receive drinks in a sippy cup. CNA #137 confirmed Resident #12's drink was not in a sippy cup. Observation on 06/02/26 at 7:22 A.M. revealed residents gathered in the dining room for the breakfast meal. Further observation revealed CNA #182 was sitting next to Resident #12 encouraging her to eat breakfast. Resident #12 had a regular cup filled with red drink. Interview on 06/02/26 at 7:31 A.M. with CNA #182 confirmed Resident #12's red drink was in a regular cup, not a sippy cup. Concurrent review of Resident #12's physician orders with CNA #182 confirmed Resident #12 had an order for a sippy cup with meals and snacks.		