STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366114	A. Building B. Wing	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Lyndhurst	1575 Brainard Rd Lyndhurst, OH 44124

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on interview, record review, and facility policy review, the facility failed to ensure a resident's request to go to bed and receive timely care was respected and the resident was timely assisted in a dignified manner. This affected one resident (#28) of three residents reviewed for dignity. The facility census was 81. Findings include: Review of the medical record for Resident #28 revealed an admitted [DATE]. Diagnoses included morbid (severe) obesity due to excess calories, lymphedema, major depressive disorder, generalized anxiety disorder, muscle weakness, and acquired absence of right leg below knee. Review of the Minimum Data Set (MDS) quarterly dated 01/28/25 revealed Resident #28 had intact cognition, was dependent on staff for transfers and toileting hygiene, was frequently incontinent of bladder, and always incontinent of bowel. Interview on 03/24/25 at 12:05 P.M. with Resident #28 revealed a few Fridays ago, he did not get put to bed due to short staffing on the night shift. Resident #28 stated by 5:00 A.M. (on 03/15/25) he still had not been put to bed and had a bowel movement. Resident #28 stated he turned on his call light multiple times, and was told by one aide that she needed to get the other aide because he required a hoyer (mechanical) lift for transfers. Resident #28 stated the aide came back and said that the other aide was on break and the resident would have to wait for assistance. Resident #28 stated when he had the bowel movement he was told by the aide again she had to find the second aide. Resident #28 stated no one came back and he didn't see anybody until the first shift arrived the following morning. Resident #28 stated Certified Nurse Aide (CNA) #256 was one of the four aides that had to clean him up and get him in bed. Resident #28 stated the night shift aide was from agency staffing. Resident #28 stated the incident was very demeaning. Review of Resident #28's progress notes was silent of documentation related to Resident #28 being left up in wheelchair and not being provided with incontinence care all night. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/27/25 at 10:13 A.M. with CNA #256 verified Resident #28 was up all night and soiled when first shift arrived to work. CNA #256 stated two aides and two nurses were scheduled on the unit, but one of the aides could not be found for hours. CNA #256 stated she believed the incident occurred the morning of 03/08/25. CNA #256 stated she had arrived early to work at approximately 6:50 A.M. and Resident #28's call light was on. CNA #256 stated there were a few call lights on when she arrived. CNA #256 started when she got to Resident #28's room she saw him up in his power wheelchair and asked him if he had an appointment. CNA #256 stated he informed her that he had been up all night and had been trying to get into bed since 1:00 A.M. CNA #256 stated he informed her that he was told by the night staff that they would come back. CNA #256 stated Resident #28 was upset and appeared tired. CNA #256 stated Resident #28 usually went to be late. CNA #256 stated the resident requested his call light not be turned off until care was performed, as night staff kept turning off his call light. CNA #256 stated Resident #28 told her that around 1:00 A.M. he had a bowel movement and wanted to get into bed so they could change him. CNA #256 confirmed the resident did have a bowel movement, and recalled it looked like he had been sitting in it for a while at the time care was provided. CNA #256 stated she also observed the resident's urinal was full, and two cups were also full of urine. CNA #256 stated she knew those were his favorite cups. CNA #256 stated she had reported the incident to Registered Nurse (RN) #258 and believed the nurse reported it to someone. CNA #256 stated she was made aware the aide from agency was put on list to not return to the facility. Interviews on 03/27/25 at 11:33 A.M. and 1:11 P.M. with RN #258 via phone verified the incident regarding Resident #28 occurred and stated she was the dayshift nurse for Resident #28 that weekend. RN #258 stated she could not recall the date of the weekend or the day it occurred. RN #258 stated when she came in she went to his room and care was provided immediately. RN #258 stated she assessed him and gave him his morning medications and told him to get some rest. RN #258 stated she reported it to the manager on duty but could not remember who that was. RN #258 stated she was distraught about the incident and Resident #28 was upset but ready to go to bed. RN #258 stated all the aides helped, got him fresh sheets, and he was in bed by 7:15 A.M. RN #258 stated she did not get report from the night nurse until Resident #28 received care. RN #258 stated the night nurse was still there and she was aware of what happened, and she told the night nurse that was unacceptable. RN #258 stated the night nurse did not say what happened on nights and the resident never said to her he felt he was neglected or abused. RN #258 stated she checked on him throughout her shift. RN #258 stated she did not make a note or document in Resident #28's medical record the events of Resident #28's concern. Interviews on 03/27/25 at 12:02 P.M. and 2:41 P.M. with Human Resources Director (HRD) #240 revealed she was the manager on duty on duty the weekend of 03/15/25 to 03/16/25 and recalled being told by staff Resident #28 did not get to bed at the time he liked. HRD #240 stated the incident did not occur on the weekend of 03/08/25. HRD #240 stated the morning of 03/16/25 at 6:57 A.M. she was told by the unit manager that was on call that the agency aide did nothing all night and needed to be placed on the do not return list. HRD #240 stated when she arrived at the facility between 9:30 A.M. and 10:30 A.M., she observed nursing staff at the nurses' station upset and they made her aware of what had occurred. HRD #240 stated when she went to talk with Resident #28 he was sitting up in bed and he stated he was fine. HRD #240 stated she then started collecting statements from the staff regarding the incident. HRD #240 stated she had informed the Administrator and Nurse Manager (NM) #261 what she was told about Resident #28 being left in his chair and not being changed all night. HRD #240 provided written statements from some staff but stated she did not have a written statement from Resident #28 or RN #258. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/27/25 at 12:54 P.M. with NM #261 revealed she was on call both days 03/15 and 03/16. NM #261 stated she was aware that Resident #261 did not get his shower that evening on 03/15/25. NM #261 stated she got a call from the weekend manager and called into the building on 03/16/25 to ensure they gave Resident #28 a shower. NM #261 stated she was not aware of him being left in his chair all night. NM #261 stated he stays up late by his choice, but he does go to bed. NM #261 stated she was not aware of any resident not being put into bed or concerns related to timely incontinence care not being provided for any residents Review of the handwritten statements provided revealed statement by HRD #240 dated 03/16/25 revealed she was the weekend manager on the weekend, 03/15/25 and 03/16/25. When she arrived on 03/16/25, she began her rounds of the building and when she stopped at the nursing station, RN #258 and CNAs #265, #258, #267, and an agency CNA #600, were all letting her know that Resident #28 was out of his bed and left up in his chair all night. CNA #253, the night aide from 03/15/25, was called and stated she put Resident #28 to bed both nights. She told her that she wasn't sure why she was being told this by staff and that and she looked more into this issue. She asked Resident #28 how he was doing, and he stated he was fine. She apologized to him for this happening and assured that they will not let this happen again. NM #261 made her aware that the agency aide needed to be on the do not return list for poor performance. She attempted to reach out the agency aide to obtain a statement but was unsuccessful in reaching her. Review of the handwritten statement dated 03/16/24 by agency CNA #600 revealed she was working day shift and upon arrival it was brought to their attention that their resident had been up in his chair all night and needed care. The manager on duty, HRD #240 was notified by staff, and the incident was quickly handled. The resident was properly taken care of and free from any additional problems. Review of the handwritten stated dated 03/16/25 by CNA #256 revealed when they arrived for day shift, Resident #28's call light was on, and she went to check on him because it was early. She found him in his chair, and he explained to her what happened and that he wanted to lay down. She then grabbed the nurse, and she reported it to the manager on duty. The statement stated this incident occurred on the morning of 03/16/25. Review of the handwritten statement by HRD #240 dated 03/16/25 revealed HRD #240 interviewed LPN #254 regarding Resident #28. LPN #254 stated that the aide was working on putting Resident #28 to bed. When she went to go check on him, Resident #28 said he was fine and continued to sleep in his chair and did not request to go into his bed. Review of the handwritten stated dated 03/17/25 by CNA #253 revealed on 03/15/25 and 03/16/25, when she was assigned to care for Resident #28, she put him in the bed on both nights. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/27/25 at 2:59 P.M. with the Administrator stated the weekend manager for the weekend of 03/15/25 -03/16/25, HRD #240 had concerns about Resident #28 not being placed in bed. She told HRD #240 to get statements, investigate it, and follow-up with Resident #28 to make sure he was ok. The Administrator stated he was fine at that time after the incident had occurred. The Administrator stated HRD #240 gave her the statements and she talked to the staff making sure that they were putting residents to bed timely. The Administrator stated she talked to the one aide that worked that night but was not sure of her name. The Administrator stated she also contacted the night nurse, LPN #254, she basically seconded the resident was sleeping in his chair and said he was fine. The Administrator stated she did not give a time of when she checked on him, and then stated she was not able to give a time. The Administrator stated she did not follow up with Resident #28 and then stated he never brought the concern directly to her. The Administrator stated the aide told her via phone that she put him to be as he requested. The Administrator stated Resident #28 at that time was not alleging neglect, although he was upset, but she saw it as a customer service issue. The Administrator stated she had done a recent customer service but was not sure if it was in regard to this particular incident. The Administrator stated the agency aide was put on the do not return list but was not his aide at that time. Interview on 04/01/25 at 1:28 P.M. with CNA #253 via phone revealed on the weekend of 03/15/25 on the night shift there was an agency aide that worked that night, and she had the hall where Resident #28 resided. CNA #253 stated the agency aide left leaving her and the nurse on the floor and she needed help from nurse to do rounds. CNA #253 stated they didn't realize she had left until around 3:00 A.M. - 4:00 A.M. CNA #253 stated the nurse found the agency aide sitting in the lobby told her to get back on the floor, but she didn't. CNA #253 stated the agency aide sat out there until 7:00 AM. and then wanted the nurse to sign her out. CNA #253 stated the agency aide was reported and she had not seen her back. CNA #253 stated she did not recall or was not sure if Resident #28 was in bed that night of 0315/25 but stated every time she was assigned to him she always got in in bed. Interview on 04/01/25 at 2:22 P.M. with LPN #254 via phone stated she was new and had worked for the facility for one week at the time of the incident with Resident #28 on the weekend of 03/15/25-03/16/25. LPN #254 stated the agency aide said to her that got Resident #28 to bed and she left around 3:00 A.M. 04:00 A. M. LPN #254 stated she never went back there until she gave Resident #28 his morning medication, his tramadol and Synthroid, she believed maybe around 5:00 A.M.-6:00 A.M. LPN #254 stated Resident#28 was sleeping in his chair and she woke him up to give him his medications. LPN #254 stated she assumed he was one of those residents that slept in his chair, and he never said anything to her. LPN #254 stated the agency aide left after she told her she had put him to bed, but they had not realized she had left. LPN #254 stated the agency aide had left the building leaving one aide on the floor and she and the other nurse had to help that one aide with check and changes. LPN #254 stated to be honest she was not sure if Resident #28 had rung his call light that night. LPN #254 stated she did not know it was an issue until the morning shift came in freaking out. Review of the policy Resident Self Determination and Participation dated August 2022 revealed the facility respects and promotes the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life. Each resident is allowed to choose activities and schedule health care, including daily routines such as sleeping and waking, and personal care needs, that are consistent with his or her interest, values, assessment and plans of care.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on observations, record review and interview, the facility failed to ensure residents had access to their personal property in a timely manner. This affected one resident (#40) of one resident reviewed for personal property. The facility census was 81. Findings include: Review of the medical record for Resident #40 revealed an admitted [DATE]. Diagnoses included amyotrophic lateral sclerosis (ALS), chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), pulmonary hypertension due to lung diseases and hypoxia, moderate protein-calorie malnutrition, major depressive disorder, and anxiety disorder. Review of the care conference review dated 01/24/25 revealed Social Worker (SW) #234, Nurse Manager (NM) #261, rehab representative, and Resident #40 attended. Under the summarization of discussion of care plan revealed: care meeting schedule with the resident on 01/24/25. Resident #40 has no family or friends to attend the meeting. Social services went over services and code status. The unit manager went over medications and level of care. Therapy went over progress and goals. Resident #40 has no support system in place. Resident #40 stated that she needs her personal items from the prior nursing facility. Resident #40 has no concerns at this time. Social services will continue to support as needed. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #40 had intact cognition, had no behaviors, and was dependent on staff for all activities of daily living (ADL). Interview on 03/24/25 at 11:39 A.M. with Resident #40, stated she wanted to get dressed and up in her wheelchair. Observation of Resident #40 revealed she was lying in her bed in a hospital gown. There was no observed wheelchair. She stated all her clothes, and her wheelchair was still at her previous facility. Further observation of Resident #40's closet and room revealed no personal items or clothing. Interview on 03/27/25 8:23 A.M. with NM #261 revealed she was familiar with Resident #40 from a previous facility and stated she has clothes, several totes and an electric wheelchair. NM #261 stated Resident #40 did not have any family or friends that could bring her personal items to the facility, so she had volunteered to pick up her items. NM #261 stated she has a jeep but had to make time to go pick up the resident's property. NM #261 stated SW #234 had reached out to the facility that has her items, and they stated they will not bring them but would hold her items. NM #261 verified since Resident #40 has been at the facility she has not had any of her personal items due to her not having time to get them. NM #261 stated Resident #40 has not expressed to her that she wanted to get up out of bed. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/27/25 at 9:41 A.M. with SW #234 stated it was not typically part of her responsibility to ensure residents had their personal items when they were admitted to the facility. SW #234 stated however, she did track down Resident #40's personal property at a facility prior to the last facility. SW #234 stated on two occasions Resident #40 mentioned to her about wanting her personal items earlier into her admission. SW #234 stated they were attempting to make arrangements to pick up her personal items, but there had been issues with the switching of management companies prior to getting new owners last week. Interviews on 04/01/25 at 9:59 A.M. and 12:44 P.M. with the Administrator stated there was no specific timeframe, but within days or a week, for them to pick up a resident's personal property from their previous facility if the resident did not have family to bring it. The Administrator stated Resident #40 had been to several facilities and they had to locate where her items were and believed on 03/27/25 they picked up her items. The Administrator stated it was a long time, but they did pick up the items. The Administrator verified it was documented in the care conference dated 01/24/25 that the resident said she wanted her personal items.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on record review, observation, interview and facility policy review, the facility failed to ensure the call lights were within reach for Resident #5 and #21. This affected two residents (#5 and #21) of three residents reviewed for call light use. The facility census was 81. Findings include: 1. Record review for Resident #21 revealed an admitted [DATE]. Diagnoses included functional quadriplegia, hemiplegia and hemiparesis, and encounter for attention to gastrostomy. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #21 was cognitively intact. Resident #21 had impairment on one side of the upper and lower extremities, was dependent on staff for activities of daily living (ADL), including bed mobility. Resident #21 had a feeding tube. Observation on 03/24/25 at 2:28 P.M. revealed Resident #21 was lying in bed. Resident #21 requested the surveyor assist her with turning and repositioning stating she was uncomfortable. Observation revealed Resident #21's call light was on the floor. Resident #21 verified she was unable to reach her call light, but she really needed turned. Observation and interview on 03/24/25 at 2:31 P.M. with Certified Nursing Assistant (CNA) #267 confirmed Resident #21's call light was out of reach and lying on the floor. 37096 2. Review of the medical record for Resident #5 revealed an admitted [DATE]. Diagnoses included cerebrovascular disease, dementia, psychotic disturbance, mood disturbance and anxiety, and dysphagia (difficulty swallowing). Review of the MDS assessment dated [DATE] revealed Resident #5 had moderate cognitive impairment and was dependent on staff for personal hygiene and transfers. Observation on 03/24/25 at 11:05 A.M revealed Resident #5 was lying in bed and his left arm was constricted. The call light was wrapped around the right-side bed rail. Interview at this time with Resident #5 stated he was unable to reach his call light. Interview on 03/24/25 at 11:10 A.M. with Housekeeper #242 verified the call light was not within reach for Resident #5. Review of the facility policy titled Call system, Resident dated September 2022 stated each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting, bathing facilities and from the floor. This deficiency represents non-compliance investigated under Complaint Number OH00163018.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, interview, record review, and review of the facility policy, the facility failed to respect and promote resident self-determination. This affected two resident (#9 and #60) of three residents reviewed for the ability for residents to choose important facets of their lives. The facility census was 81. Findings include: 1.Record review for Resident #9 revealed a readmitted [DATE]. Diagnosis included paraplegia, incomplete, anxiety disorder, and weakness. Review of the quarterly Minimum Data Set (MDS) dated [DATE] for Resident #9 revealed Resident #9 was cognitively intact. Resident #9 had impairment on both sides of the lower extremities and used a wheelchair for mobility. Resident #9 required partial/moderate assistants for bed mobility and dependent for transfers to and from the wheelchair. Vision was adequate with corrective lenses. Review of the care plan for Resident #9 dated [DATE] revealed Resident #21 was at risk for impaired psychiatric/mood status related to diagnosis of depression and attention deficit hyperactivity disorder. Interventions included to provide a calm safe environment when patient is emotional or frustrated and allow time to voice feelings. Refer to social worker as needed if resident communicates the need to speak with someone. Review of the Resident Council minutes dated [DATE] signed by Administrator revealed under the area of Social Services, Residents would like the ancillary services to be posted in rooms. Interview on [DATE] at 2:13 P.M. with Resident #9 revealed he had asked the social worker at least 17 times to let him know when the ancillary services were coming into the facility. Resident #9 reported the social worker had refused and stated the information was posted. Resident #9 stated. he could not always get up there, and needed a second pair of glasses and he never knew when the anciallary services would be coming into the building. Resident #9 revealed he leaves the facility at times for different appointments that he schedules and would like to know in advance when the eye doctor, podiatrist, and dentist were coming so he can plan his schedule and plan to meet with them if needed. Resident #9 revealed he needed a second pair of glasses and wanted to make sure he did not miss the eye doctor's next visit. Interview on [DATE] at 10:51 A.M. with Licensed Social Worker (LSW) #234 confirmed she scheduled all the ancillary service (Podiatrist, Optometry, Dental) visits. LSW #234 confirmed these services are provided at the facility as scheduled by her and each resident had the right to receive the ancillary services. LSW #234 confirmed Resident #9 spoke with her and requested she post the ancillary visit dates. LSW #234 stated, I said they are posted everywhere, he said you need to put them in everyone's room, and I said I am not doing that. LSW #234 confirmed she had the ancillary services dates posted everywhere for residents to see when they are scheduled to visits. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation [DATE] at 10:52 A.M. with LSW #234 during a walk through of the entire facility where residents resided, revealed the only posted ancillary services expected dates to visit were posted in the secured memory care unit and those were expired dates. LSW #234 revealed she had ancillary schedule for [DATE] completed for when they were coming but she must not of posted the new schedule yet. Interview on [DATE] at 10:59 AM with Administrator revealed any resident who requested a copy posted in their room of the ancillary service visit dates should have it posted in their room per their request. 2. Record review for Resident #60 revealed an admitted [DATE]. Diagnosis included rhabdomyolysis, osteoarthritis, and muscle weakness. Review of the Medicare 5-day MDS assessment dated [DATE] revealed Resident #60 was cognitively intact. Resident #60 had impairment to one side of the upper extremity, was dependent for toileting and required partial/moderate assistants with shower/bathing. Review of the care plan dated [DATE] for Resident #60 revealed the resident is, dependent on staff for activities, cognitive stimulation, and social interaction related to physical limitations. Interventions included to honor resident's choices and preferences whenever possible. Review of Shower Schedule revealed showers/baths were completed on all three shifts (7:00 A.M. to 3:00 P. M., 3:00 P.M. to 11:00 P.M. and 11:00 P.M. to 7 :00 A.M.). The showers were scheduled per shift by room number. Record review revealed Resident #60's showers were to be completed on Mondays and Thursdays from 11:00 P.M. to 7:00 A.M. Record review of Resident #60's medical record revealed Resident #60's preferences/care plan were not completed to include the time of day she preferred her bath/showers. Interview on [DATE] at 3:53 P.M. with Resident #60 revealed the staff told her she was supposed to get her showers/baths on the night shift, 11:00 P.M. to 7:00 A.M.; Resident #60 revealed she felt that was crazy and revealed she was never asked when she wanted them, she was just told that was when she was scheduled to have them. Resident #60 revealed when the staff did come in, in the middle of the night and wake her up, she would tell them it's late so then they would say she refused. Resident #60 revealed she wasn't refusing her showers, she just did not want to have to get them in the middle of the night when she was sleeping. Review of the shower schedule and Resident choices with Administrator and Unit Manager RN #257 on [DATE] at 5:16 P.M. confirmed Resident #60 was scheduled to receive her showers on the 11:00 P.M. to 7:00 A.M. shift two days a week. Administrator and Unit Manager RN #257 confirmed the forms were not completed for Resident #60 on admission to determine her preferences for dates and times to receive showers/baths. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Resident Self Determination and Participation revised [DATE] revealed our facility respects and promotes the right of each resident to exorcize his or her autonomy regarding what the resident considers to be important facets of his or her life. Each resident is allowed to choose activities, and schedule health care and healthcare providers, that are consistent with his or her interest, values, assessments and plan of care, including daily routine such as sleeping and waking, exercise and bathing schedules. Residents are encouraged to interact with members of the community and participate in community activities inside and outside the community. Examples of accommodations that support community participation include scheduling treatments or therapy so they do nit interfere with activities or events and assisting the resident with planning.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on record review and interview, the facility failed to ensure a completed code status form was completed for Resident #40. This affected one resident (#40) of one resident reviewed for advanced directives. The facility census was 81. Findings include: Review of the medical record for Resident #40 revealed an admitted [DATE]. Diagnoses included amyotrophic lateral sclerosis (ALS), chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), pulmonary hypertension due to lung diseases and hypoxia, moderate protein-calorie malnutrition, major depressive disorder, and anxiety disorder. Review of the physician orders for March 2025 revealed Do Not Resuscitate Comfort Care Arrest (DNRCC-A) with a start date of 01/23/25. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #40 had intact cognition, had no behaviors, and was dependent on staff for all activities of daily living (ADL). Interview on 03/25/25 at 2:19 P.M. with the Administrator verified the order for DNRCC-A was written, but the form was never completed. The Administrator stated she had the nurse practitioner come in today to do the form it and was uploaded into Resident #40's electronic medical record with today's date.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on record review, interview and facility policy review, the facility failed to ensure notification of significant weight loss to the resident's physician and/or the resident representative. This affected one resident (#45) of seven residents reviewed for nutrition and one resident (#35) of one resident reviewed for tube feeding. The facility census was 81. Findings include: 1. Review of the medical record for Resident #35 revealed an admitted [DATE]. Diagnoses included dementia, adult failure to thrive, dysphagia, Alzheimer's disease with early onset, gastrostomy status, and moderate protein-calorie malnutrition. Review of the weight history for Resident #35 revealed: 02/03/25 weight was 134 pounds 02/20/25 weight was 137 pounds 02/27/25 weight was 130 pounds 03/12/25 weight was 130.5 pounds Review of the progress note dated 03/06/25 at 10:07 A.M. revealed a nutrition noted stating Resident #35's weights were reviewed. Resident #35 showed a weight loss on the last weight after a previous weight gain. Resident #35 was on weekly weights to monitor, awaiting weekly weight to confirm weight loss. Resident #35 receives nothing by mouth (NPO) and receives all of nutrition via percutaneous endoscopic gastrostomy (PEG) tube (feeding tube). No new recommendations. Will follow up after weekly weight obtained. There was no documentation of notification to the physician/nurse practitioner or resident family/representative. Interviews on 03/27/25 at 1:59 P.M. and at 2:13 P.M. with Diet Technician (DT) #401 stated she would notify the residents' family of significant weight loss, and the nurse unit managers would notify the doctors. DT #401 stated she would document in the resident medical record that she had notified the resident's family. DT #401 stated she was not 100% positive that she notified Resident #35's family of the weight loss. DT #401 verified she did not document that she notified Resident #35's family. Interview on 03/27/25 at 3:53 P.M. with Nurse Practitioner (NP) #352 via phone stated she was not aware of Resident #35's weight loss, but if she was notified, she would have seen the resident and noted it. NP #352 stated Resident #35 had been stable medically based on her assessments. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #45 revealed an admitted d of 10/11/24. Diagnoses included intraoperative cerebrovascular infarction, traumatic subdural hemorrhage with loss of consciousness, multiple fractures, gastrostomy, dysphagia, and moderate protein-calorie malnutrition. Review of the weight history for Resident #45 revealed: 10/11/24 weight was 141 pounds 10/24/24 weight was 138.2 pounds 03/11/25 weight was 125 pounds 03/21/25 weight was 125 pounds Review of the progress notes dated 03/13/25 at 1:33 P.M. revealed a nutrition note stating, spoke with the resident's mother about weight loss today. Resident #45 was unable to be weighed for a period of time per physician orders. Resident #45 will now be weighed weekly to monitor for ongoing trend. Will reevaluate tube feeding as needed. Resident #45 is also now receiving a regular mechanical soft diet with honey thick fluids and needs set up and limited assist at times. Resident #45 was discussed in the interdisciplinary meeting today. Will continue to monitor and follow up as needed. Review of the physician note dated 03/13/25 revealed no nursing concerns, no fevers or chills. There was no documentation of notification to the physician/nurse practitioner or resident family/representative. Interview on 03/27/25 at 5:11 P.M. with the Administrator after reviewing the progress notes and physician/nurse practitioner notes for Residents #35 and #45 verified there was no documentation of notification to the physician/nurse practitioner for Resident #45 and to the physician/nurse practitioner and resident representative for Resident #35 of their significant weight loss. Review of the facility policy Change in a Resident's Condition or Status, revised February 2021, revealed the facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.).

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39968 Based on review of Notice of Medicare Non-Coverage (NOMNC) letters and staff interview, the facility failed to provide residents with the correct last covered day (LCD). This affected five (Resident #60, Resident #63, Resident #73, Resident #79, and Resident #80) of eleven residents reviewed for liability notices. The census was 81. Findings include: 1. Review of Resident #60's medical record revealed she was admitted to the facility on [DATE]. She was still a resident and had not been discharged . A NOMNC letter revealed skilled services ended on 02/15/25, the LCD. The medical record provided no evidence of Resident #60's next payor source starting on 02/16/25. 2. Review of Resident #63's medical record revealed she was admitted to the facility on [DATE]. She was still a resident and had not been discharged . A NOMNC letter revealed skilled services ended on 11/23/24, the LCD. The medical record provided no evidence of Resident #63's next payor source starting on 11/24/24. 3. Review of Resident #73's medical record revealed he was admitted to the facility on [DATE]. He was still a resident and had not been discharged . A NOMNC letter revealed skilled services ended on 03/21/25, the LCD. The medical record provided no evidence of Resident #73's next payor source starting on 03/22/25. 4. Review of Resident #79's medical record revealed he was admitted to the facility on [DATE] and was discharged on [DATE]. A NOMNC letter revealed skilled services ended on 02/04/25, the LCD. The medical record provided no evidence of Resident #79's reason for leaving the facility on the LCD. 5. Review of Resident #80's medical record revealed he was admitted to the facility on [DATE] and was discharged on [DATE]. A NOMNC letter revealed skilled services ended on 01/11/25. The medical record provided no evidence of Resident #80's reason for leaving the facility prior to the LCD. Interview on 03/25/25 at 3:00 P.M. with Licensed Social Worker (LSW) #234 confirmed the discrepancies noted about the last covered days (LCD) and there were no progress notes to explain a change in LCD or payor concerns

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on record reviews, observations and interviews, the facility failed to ensure a clean and sanitary environment for Resident #5 and a comfortable mattress in good repair for Resident #61. This affected two residents (#5 and #61) reviewed for a clean, sanitary, and homelike environment. The facility census was 81. Findings include: 1. Review of the medical record for Resident #61 revealed an admitted [DATE]. Diagnoses included quadriplegia, anxiety disorder, contracture right and left hand, reduced mobility, and muscle weakness. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #61 had intact cognition and required substantial/maximin assistance from staff for bed mobility and was dependent on staff for chair/bed to bed/chair transfers. Interview on 03/24/25 at 11:43 A.M. with Resident #61 stated her bed was uncomfortable, and it sunk in the middle. The resident stated she informed some the aides but did not know their names. Interviews on 03/27/25 at 10:13 A.M. and 04/01/25 at 10:23 A.M. with Certified Nurse Aides (CNAs) #256 and #277 stated the concern with Resident #61's mattress had been going on for about a month. CNA #256 stated Resident #261 complained that she could feel the rails. CNA #256 stated she informed Director of Maintenance (DOM) #266 directly about a month ago. CNA #277 stated she informed the nurse but could not recall the nurse she informed because it had been a while ago. Observation on 03/27/25 at 12:49 P.M. of Resident #61 sitting in a chair in her room next to her bed. At this time, Interview with Resident #61 revealed she was not comfortable in her chair, but they tried to make it comfortable by adding pillows. Resident #61 then pointed to her bed and stated, see. Observation of Resident #61's bed revealed it was made but there was a large dip in the middle of the mattress. Resident #61 stated it had been that way for about a month, and she could not remember who the aides were, but they were aware of the dip. Observation on 03/27/25 at 12:53 P.M. with Nurse Manager (NM) #261 of Resident #61's bed. At this time, Interview with NM #261 verified the large dip in mattress and stated she would get her a new mattress. NM #261 stated the mattress was a regular mattress not an air mattress. Observation on 03/27/25 at 1:00 P.M. of DOM #266 walking down the hall with a mattress in a plastic covering. Interview at this time with DOM #266 stated he was not sure if he was made aware of her needing a new mattress, and he would have to check the maintenance logs. Reviewed on maintenance logs dated 01/27/25 through 03/28/25 revealed no documented concerns related to Resident #61's mattress. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Follow-up interview on 04/01/25 at 8:19 A.M. with DOM #266 verified there were no concerns on the maintenance logs related to Resident #61's mattress. DOM #266 stated 03/27/25 was the first time he was made aware of Resident #61 needing a new mattress. 37096 2. Review of the medical record for Resident #5 revealed an admitted [DATE]. Diagnoses included cerebrovascular disease, dementia, psychotic disturbance, mood disturbance and anxiety, and dysphagia (difficulty swallowing). Review of the MDS assessment dated [DATE] revealed Resident #5 had moderate cognitive impairment and was dependent on staff for personal hygiene and transfers. Observation on 03/24/25 at 11:05 A.M, revealed Resident #5 was lying in bed. The resident had a floor mat to the right side of the bed. The mat was covered with a dried white substance. The carpeted next to the mat had large areas with a dried white substance. Interview 03/24/25 at 11:10 A.M. with Housekeeper #242 verified the dirty floor mat and spillage on the carpet. Housekeeper #242 stated she did not get to clean Resident #5 room today. This deficiency represents non-compliance investigated under Complaint Number OH00163018.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on record review, observation, interview, and review of the facility policy, the facility failed to ensure quarterly care plan meetings were offered/completed for Resident #13. This affected one resident (#13) of one resident reviewed for quarterly care plan timing. The facility census was 81. Findings include: Record review for Resident #13 revealed an admitted [DATE]. Diagnoses included cerebral infarction, neuromuscular dysfunction of the bladder, obstructive and reflux uropathy, resistant to multiple antimicrobial drugs, constipation, and muscle weakness. Review of the modification of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 was cognitively intact. Resident #13 had impairment on both sides of her lower extremities, required partial/moderate assistance with eating and was dependent on staff for toilet hygiene, bathing, bed mobility, and transfers, and required substantial/maximal assistance for personal hygiene. Resident #13 had an indwelling catheter and was always incontinent of bowel. Interview on 03/24/25 at 9:53 A.M. with Resident #13 revealed she was not offered a care plan meeting quarterly. Record review of Resident #13's medical record from 04/01/24 through 03/27/25 revealed no documentation of a care plan meeting completed or refusals of a care plan meeting. Interview on 03/25/25 at 4:06 P.M. with Licensed Social Worker (LSW) #234 revealed the latest in the day she could do a care plan meeting was 2:30 P.M.; LSW #234 revealed Resident #13's daughter wanted to do it later in the day. LSW #234 confirmed Resident #13 did not have a scheduled care plan meeting set at this time and confirmed she had not had a care plan meeting over the past seven months due to Resident #13 wanting to have it when her daughter could attend and that was past 2:30 P.M. LSW #234 revealed she was unsure about any care plan meetings Resident #13 had prior to that. LSW #234 revealed she did not document any attempts made to schedule a care plan meeting with Resident #13 or the responsible party. Interview on 03/27/25 at 12:01 P.M. with Resident #13's Responsible Party revealed Resident #13 was at the facility for five years and only had two care plan meetings in five years. Resident #13's Responsible Party revealed they did schedule one months ago, and then Resident #13 became ill. Resident #13 and the Responsible Party requested she attend the care plan meeting without Resident #13 because she was not feeling well, but the facility refused. The facility staff said the resident had to be there, and the facility canceled the meeting and never rescheduled it. Resident #13's daughter revealed, at times, she requested and was denied the meeting on the phone because it was hard for her to get to the facility. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/27/25 at 12:25 P.M. with the Administrator revealed the Social Worker was to schedule quarterly care plan meetings with each resident. Expectations included doing care conferences on the phone, in the evenings if preferred, and the residents did not have to be present if they did not want to per the resident's choice. The Administrator verified Resident #13 had no documented evidence that a care plan meeting was offered over the past 12 months. Review of the facility policy titled, Resident Participation-Assessment/Care Plans, revised February 2021, revealed the resident and his or her legal guardian are encouraged to attend and participate in the resident's assessment and in the development of the resident's person-centered care plan. Facility staff support and encourage resident/representative participation in the care planning process by holding care plan meetings at times of day when the resident, representative and family members can attend. The Social Service Director/Designee is responsible for notifying the resident/representative.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, interview, record review, and review of the facility policy, the facility failed to provide hygiene and grooming as scheduled and as needed for three residents (#13, #28, and #60) of three residents reviewed for hygiene. The facility census was 81. Findings include: 1.Record review for Resident #13 revealed an admitted [DATE]. Diagnosis included cerebral infarction, muscle wasting and atrophy, and muscle weakness. Review of the Modification of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #13 was cognitively intact. Resident #13 had impairment on both sides of the lower extremities, dependent for toileting hygiene, bathing, and substantial/maximal assistants for personal hygiene. Review of the care plan for Resident #13 dated 07/24/24 revealed Resident #13 had an activity of daily living (ADL) self-care performance deficit. Resident #13 requires assistance with ADLs. Interventions included to assist with activities of daily living (i.e.: dressing, grooming, personal hygiene, toileting, bed mobility, transfers, bathing, locomotion, oral care, etc.) and adjust level of assistance and support as needed every shift. Bathing: Check nail length and trim and clean on bath day and as necessary. Record review of the Shower Schedule revealed Resident #13's showers/baths were scheduled on Mondays and Thursdays 7:00 A.M. to 3:00 P.M. Observation on 03/24/25 at 9:55 A.M. revealed Resident #13 was lying in bed. Resident #13's fingernails were long, uneven and embedded with a thick dark substance. Resident #13 revealed she was not getting her showers routinely as scheduled. Observation on 03/25/25 at 3:16 P.M. with Certified Nursing Assistant (CNA) #278 confirmed Resident #13's fingernails were long, uneven and embedded with a thick dark substance. CNA #278 walked away (without offering to assist with nail care) after observing and confirming Resident #13's fingernails. Observation on 03/26/25 at 8:33 A.M. revealed Resident #13 was lying in bed. Resident #13's fingernails were long, uneven and embedded with a thick dark substance. Resident #13 revealed the staff did not offer or assist with cleaning or trimming her nails and went on to say she would like it if they did. Observation on 03/26/25 at 8:38 A.M. with CNA #267 revealed nail care was done on shower days and as needed. CNA #267 confirmed Resident #13's nails continued to be long, uneven and embedded with a thick dark substance. CNA #267 walked away (without offering to assist with nail care) after observing and confirming Resident #13's fingernails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/26/25 at 8:58 A.M. revealed Resident #13 was sitting up in bed feeding herself breakfast. Resident #13's nails continued to be long, uneven and embedded with a thick dark substance. Review of the shower/tub bath/bed bath sheets from 01/01/25 through 03/26/25 revealed there was no bath sheet to confirm Resident #13 received or was offered a shower or bed bath on 01/02/25, 01/16/25, 01/20/25, 01/23/25, 01/27/25, 01/30/25, 02/13/25, 02/20/25, 02/24/25, 02/27/25/03/03/25, 03/06/25, 03/10/25, 03/13/25, 03/17/25, or 03/24/25. Interview on 03/26/25 at 2:41 P.M. with the Administrator confirmed there were no other shower sheets completed for Resident #13. Administrator confirmed when the shower or bath was completed, the shower sheet was also completed to confirm the shower was done. 2. Record review for Resident #60 revealed an admitted [DATE]. Diagnosis included rhabdomyolysis, osteoarthritis, and muscle weakness. Review of the Medicare 5-day MDS assessment dated [DATE] revealed Resident #60 was cognitively intact. Resident #60 had impairment to one side of the upper extremity, was dependent for toileting and required partial/moderate assistants with shower/bathing. Review of the care plan dated 01/14/25 for Resident #60 revealed Resident #60 required staff assistance with activities of daily living related to weakness, impaired mobility, fall, rhabdomyolysis, obesity, and multiple comorbidities. Interventions included to assist with activities of daily living (i.e.: dressing, grooming, personal hygiene, toileting, bed mobility, transfers, bathing, locomotion, oral care, etc.) and adjust level of assistance and support to assist with one to two staff as needed every shift. Review of Shower Schedule for Resident #60 revealed showers were to be completed on Mondays and Thursdays from 11:00 P.M. to 7:00 A.M. Interview on 03/24/25 at 3:53 P.M. with Resident #60 revealed she was not getting baths like she was supposed to. The staff told her she was supposed to get her showers/baths on the night shift, 11:00 P.M. to 7:00 A.M. Resident #60 revealed she felt that was crazy. Usually staff would not even offer her a bath/shower but when they did come in the middle of the night and wake her up, she would tell them it's late so then they would say she refused. Resident #60 revealed she wasn't refusing her showers, she just did not want to have to get them in the middle of the night when she was sleeping. Review of the shower sheets for Resident #60 from 01/31/25 through 03/26/25 revealed on 01/31/25 and 03/04/25 Resident #60 refused her bath. There was no bath sheet to confirm Resident #60 received or was offered a shower or bed bath on 02/07/25, 02/17/25, 02/20/25, 02/24/25, 03/06/25, 03/10/25, 03/17/25, 03/20/25, and 03/24/25. Interview on 03/26/25 at 2:41 P.M. with the Administrator confirmed there were no other shower sheets completed for Resident #60. Administrator confirmed when the shower or bath was completed, the shower sheet was also completed to confirm the shower was done. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the shower sheets/record with Administrator and Unit Manager RN #257 on 03/26/25 at 5:16 P.M. confirmed the shower sheets were not completed to confirm showers were completed as scheduled for Resident #13 and #60. Unit Manager RN #257 revealed if the shower sheets were not completed, that meant the shower/bath was not offered or completed. The shower records would also indicate if the bath/shower was refused. Unit Manager RN #257 revealed she shared her concerns in the past with the previous Director of Nursing (DON) that the showers were not completed as scheduled. Administrator confirmed she was also aware of concerns with Residents showers/baths not completed and the previous DON was working on it. Interview on 03/27/25 at 1:25 P.M. with LPN #304 confirmed there were times residents showers were not being offered or completed and revealed it was because at times there was just not enough time. Interview on 03/27/25 at 3:18 P.M. with CNA #306 stated, Its not that there is not enough time to complete tasks, it's some staff just don't manage their time to do it (showers) so some showers don't get done. Interview on 03/27/25 at 3:24 P.M. with CNA #256 revealed the facility used a lot of agency staff and they just don't do showers. CNA #256 stated, we all know the showers are supposed to get done but agency, they just do what they want., they'll say we did not know we were supposed to do showers even though facility staff would tell them about the facility shower book and schedule. 3. Review of the medical record for Resident #28 revealed an admitted [DATE]. Diagnoses included morbid (severe) obesity due to excess calories, lymphedema, major depressive disorder, generalized anxiety disorder, muscle weakness, and acquired absence of right leg below knee. Review of the Minimum Data Set (MDS) quarterly dated 01/28/25 revealed Resident #28 had intact cognition, was dependent on staff for transfers and toileting hygiene, was frequently incontinent of bladder, and always incontinent of bowel. Interview on 03/24/25 at 12:05 P.M. with Resident #28 revealed a few Fridays ago, he did not get put to bed due to short staffing on the night shift. Resident #28 stated by 5:00 A.M. (on 03/15/25) he still had not been put to bed and had a bowel movement. Resident #28 stated he turned on his call light multiple times, and was told by one aide that she needed to get the other aide because he required a hoyer (mechanical) lift for transfers. Resident #28 stated the aide came back and said that the other aide was on break and the resident would have to wait for assistance. Resident #28 stated when he had the bowel movement he was told by the aide again she had to find the second aide. Resident #28 stated no one came back and he didn't see anybody until the first shift arrived the following morning. Resident #28 stated Certified Nurse Aide (CNA) #256 was one of the four aides that had to clean him up and get him in bed. Resident #28 stated the night shift aide was from agency staffing. Resident #28 stated the incident was very demeaning. Review of Resident #28's progress notes was silent of documentation related to Resident #28 being left up in wheelchair and not being provided with incontinence care all night. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/27/25 at 10:13 A.M. with CNA #256 verified Resident #28 was up all night and soiled when first shift arrived to work. CNA #256 stated two aides and two nurses were scheduled on the unit, but one of the aides could not be found for hours. CNA #256 stated she believed the incident occurred the morning of 03/08/25. CNA #256 stated she had arrived early to work at approximately 6:50 A.M. and Resident #28's call light was on. CNA #256 stated there were a few call lights on when she arrived. CNA #256 started when she got to Resident #28's room she saw him up in his power wheelchair and asked him if he had an appointment. CNA #256 stated he informed her that he had been up all night and had been trying to get into bed since 1:00 A.M. CNA #256 stated he informed her that he was told by the night staff that they would come back. CNA #256 stated Resident #28 was upset and appeared tired. CNA #256 stated Resident #28 usually went to be late. CNA #256 stated the resident requested his call light not be turned off until care was performed, as night staff kept turning off his call light. CNA #256 stated Resident #28 told her that around 1:00 A.M. he had a bowel movement and wanted to get into bed so they could change him. CNA #256 confirmed the resident did have a bowel movement, and recalled it looked like he had been sitting in it for a while at the time care was provided. CNA #256 stated she also observed the resident's urinal was full, and two cups were also full of urine. CNA #256 stated she knew those were his favorite cups. CNA #256 stated she had reported the incident to Registered Nurse (RN) #258 and believed the nurse reported it to someone. CNA #256 stated she was made aware the aide from agency was put on list to not return to the facility. Interviews on 03/27/25 at 11:33 A.M. and 1:11 P.M. with RN #258 via phone verified the incident regarding Resident #28 occurred and stated she was the dayshift nurse for Resident #28 that weekend. RN #258 stated she could not recall the date of the weekend or the day it occurred. RN #258 stated when she came in she went to his room and care was provided immediately. RN #258 stated she assessed him and gave him his morning medications and told him to get some rest. RN #258 stated she reported it to the manager on duty but could not remember who that was. RN #258 stated she was distraught about the incident and Resident #28 was upset but ready to go to bed. RN #258 stated all the aides helped, got him fresh sheets, and he was in bed by 7:15 A.M. RN #258 stated she did not get report from the night nurse until Resident #28 received care. RN #258 stated the night nurse was still there and she was aware of what happened, and she told the night nurse that was unacceptable. RN #258 stated the night nurse did not say what happened on nights and the resident never said to her he felt he was neglected or abused. RN #258 stated she checked on him throughout her shift. RN #258 stated she did not make a note or document in Resident #28's medical record the events of Resident #28's concern. Review of the facility policy titled, Supporting Activities of Daily Living (ADLs) revised March 2018 revealed Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. This deficiency represents non-compliance investigated under Complaint Number OH00163010 and OH00161974.

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, interview, medical record review, review of hospice notes, and facility policy review, the facility failed to ensure care and services were provided to facilitate resident preference, comfort and hydration. Actual Harm occurred on 03/24/25 at 10:04 A.M. when Resident #58, a resident who was receiving end-of-life hospice care who staff believed was actively dying, was left alone behind a closed door, thirsty, in severe pain, and unable to call for assistance. Resident #58 was dependent on all aspects of care and unable to call for help, was denied hydration measures, and had minimal pain control for 2 days. This affected one resident (#58) of three residents reviewed for quality of care and treatment. The facility census was 81. Findings include Review of Resident #58's medical record revealed an admitted [DATE]. Medical diagnoses included amyotrophic lateral sclerosis (ALS) (a progressive disease that specifically affects motor neurons responsible for controlling muscle movement, leading to muscle weakness and paralysis), chronic pain syndrome, weakness, lack of coordination, and a need for assistance with personal care. Review of Resident #58's care plan dated 02/22/24 revealed the resident was at risk for altered nutrition/hydration status related to ALS. Interventions included administering medications as ordered, providing total assistance with meals and snacks, encouraging consumption of fluids provided, and monitoring for signs and symptoms of dehydration. An additional care plan focus dated 12/04/24 revealed the resident required hospice care due to end of life processes, with a terminal diagnosis of ALS. Listed interventions included administering medications for comfort prior to activity or care and to keep the resident comfortable to the extent possible. An additional care plan focus dated 02/21/25 revealed Resident #58 was receiving opioid pain medication for pain control. Interventions included administering medication as ordered, assessing pain type, location and characteristics before and after administration of as-needed pain medication, and encourage fluid intake. An additional intervention included to monitor symptoms of a potential overdose including constricted pupils, loss of consciousness, shallow breathing, respiratory depression, limp body, or pale, cold, or clammy skin. Review of the Hospice Skilled Nursing Communication note dated 01/16/25 revealed Resident #58 needed a blow call light (a call light that can be activated by blowing air into a small tube) due to a decreased range of motion to the resident's left hand. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #58's Minimum Data Set (MDS) annual assessment dated [DATE] revealed the resident was cognitively intact. Resident #58 had impairment on both sides of the upper and lower extremities and was dependent on staff for all activities of daily living, including eating. Resident #58's daily preferences, including having snacks available between meals, were listed as very important to her. Resident #58 was noted to have anxiety and depression and received scheduled and as-needed (PRN) pain medication. Resident #58 was noted to receive hospice services and to have a disease that may result in a life expectancy of less than six months. Review of Resident #58's physician's orders revealed an order dated 02/27/25 which stated the resident was admitted to hospice services with a diagnosis of ALS. Review of Resident #58's physician's orders revealed on 03/22/25, all of Resident #58's routine scheduled medications, including Robaxin (a muscle relaxer used to treat painful muscle spasms) 750 milligram (mg) tablet twice daily, Morphine Sulfate Extended Release (ER) (an opioid analgesic used to treat severe pain) 30 mg every eight hours routinely, and Gabapentin (an anticonvulsant and pain adjunct commonly used to treat nerve pain) 900 mg four times daily routinely, were discontinued. Resident #58 had as-needed Morphine Sulfate 20 mg/milliliter (ml) 1 ml ordered as needed for pain related to ALS. There was no documented evidence of a physician order for Resident #58 to have nothing by mouth (NPO) or any orders related to limiting hydration. Review of the Hospice Skilled Nursing Communication note dated 03/22/25, completed by Hospice Registered Nurse (RN) #801, revealed to discontinue all medications, except comfort medications, as Resident #58 was actively transitioning (dying). Review of Resident #58's Medication Administration Record (MAR) for March 2025 reflected all routine medications, including scheduled Robaxin, Morphine Sulfate, and Gabapentin, had been discontinued on 03/22/25. The MAR noted only one as-needed dose of Morphine Sulfate 1 ml had been administered (on 03/23/25 at 6:30 P.M.) since the routine medications had been discontinued. The MAR recorded the effectiveness of the pain medication dose as a U, noting it was unknown if the medication had been effective to treat Resident #58's pain. Review of Resident #58's nursing progress notes revealed a note dated 03/23/25 at 8:01 P.M., authored by RN #323, which revealed Resident #58 remained more alert throughout the shift, discussed with staff and family members. The note stated Resident #58 was able to express her needs. Resident #58 had refused all meals but tolerated sips of fluid well. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Observation on 03/24/25 at 10:04 A.M. revealed the door to Resident #58's room was closed. A sign was posted next to Resident #58's door which stated, please don't close my door unless asked. Upon knocking and opening the door, Resident #58 was observed lying in bed, with both of her arms positioned to her side, and her head lifted off the bed. Her eyes were wide as she looked towards the doorway. Resident #58 repeatedly mouthed the words help me, help me. Resident #58 was observed with tears in her eyes, was able to mouth words clearly, but had no sound projection. Resident #58 stated she was so thirsty and requested a drink. Resident #58's lips were very dry, and her lips stuck together as she mouthed her words. Three Styrofoam cups of water and a half-full bottle of soda was on the resident's bedside table. Resident #58 shared she was unable to move her arms or legs due to ALS. Resident #58 additionally stated that she was unable to use her call light to summon staff assistance, as she also could not move her hands. Further review revealed Resident #58 had a push-button call light next to her left hand. When asked, Resident #57 was unable to move her hand to activate the call light button. Resident #58 continued to mouth help me, help me, and the surveyor exited the room to summon staff assistance. Observation on 03/24/25 at 10:06 A.M. revealed Certified Nursing Assistant (CNA) #265 walked up the hall. CNA #265 was informed Resident #58 requested help and was thirsty. CNA #265 stated she is actively dying; she can't have anything to drink as she was ordered nothing by mouth (NPO). CNA #265 entered Resident #58's room and confirmed there were three cups of water and a half-full bottle of soda on the bedside table and confirmed the sign next to the door. CNA turned to leave Resident #58's room, who mouthed the words don't close, please don't close, referring to the door. CNA #265 confirmed the resident was unable to use her pushed button call light and walked away. The surveyor exited Resident #58's room to find the resident's assigned nurse. A few minutes later, CNA #265 again walked up the hall and stated Resident #58's nurse was on a break, but the Director of Nursing (DON) had stated she could give Resident #58 a drink. CNA #265 shared that her shift started at 7:00 A.M. and she had not yet been into Resident #58's room to provide care nor had she offered the resident anything as she was told Resident #58 was NPO. CNA #265 entered Resident #58's room, where Resident #58 stated she had not had anything to drink since the previous day. Resident #58 stated she had asked staff multiple times, but had been told no, she was not allowed to have anything to drink. Resident #58 additionally stated she had pain everywhere and rated her pain at a 10 on a scale of 1-10, with 10 being the worst pain she could imagine. Interview on 03/24/25 at 10:10 A.M. with RN #262 revealed she was Resident #58's primary nurse. RN #262 was informed Resident #58's pain level was a 10 and her pain was all over. RN #262 stated she had other tasks, including administering another resident's tube feeding, before she could provide any pain medication to Resident #58. Observation on 03/24/25 at 10:13 A.M. revealed RN #262 returned to the surveyor and stated she would address Resident #58's pain. RN #262 revealed Resident #58 was actively dying and was NPO status over the weekend because of her medical diagnosis. RN #262 stated hospice made the Resident #58 NPO status over the weekend as she had been lethargic and it was a bad weekend for the resident. RN #262 confirmed Resident #58 was alert and oriented and revealed she could have pain medications when needed. RN #262 approached the medication card to prepare the resident's dose of pain medication. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Observation on 03/24/25 at 10:37 A.M. revealed Hospice RN #801 walked up the hall. Hospice RN #801 confirmed she was Resident #58's hospice nurse and stated the resident was actively transitioning. Hospice RN #801 confirmed she had visited Resident #58 on 03/22/25, at which time Resident #58 was comatose. Hospice RN #801 discontinued all of Resident #58's routine medications, including all routine pain medications, due to the resident's change in condition. Hospice RN #801 revealed there was never a written order for Resident #58 to be NPO. When asked if she had instructed the staff caring for Resident #58 to treat the resident as NPO, Hospice Nurse #801 repeated there was never a hospice-initiated order for Resident #58 to be NPO. Upon entering Resident #58's room, the door to the resident's room was again observed to be closed. Resident #58 remained in bed alone behind the closed door and unable to use her call light or make any purposeful movement. Further review of Resident #58's medical record revealed no evidence or documentation Resident #58's physician had been notified of Resident #58's decline on 03/22/25 or the staff withholding fluids. Interview on 04/01/25 at 2:43 P.M. with Resident #58 revealed she still had a push button call light she was unable to use. Resident #58 stated she had been receiving some fluids over the last few days and was thankful. Resident #58 stated hospice was still working on getting her a blow call light. During the interview, Resident #58's voice was noted to have sound projection and her voice sounded stronger than during prior interviews on 03/24/25. Interview on 04/02/25 at 11:49 A.M. with the Administrator confirmed she was aware Resident #58 needed a blow call light. The Administrator confirmed staff discussed it, but she did not remember the outcome. Interview on 04/02/25 at 12:35 P.M. with the DON confirmed there was no documentation that Resident #58's physician had been notified of Resident #58's change in condition or the withholding of fluids. The DON revealed the staff were only notifying the contracted hospice provider and stated the resident's physician should be notified with any change in condition, even when the resident was receiving hospice services. Review of the policy Hydration - Clinical Protocol revised September 2017 revealed the staff, with the physician's input, will identify and report to the physician individuals with signs and symptoms (for example, delirium, lethargy, increased thirst) or lab test results that may reflect fluid and electrolyte imbalance. The physician and staff will identify significant risks for subsequent fluid and electrolyte imbalance, to include, for example, individuals who are not eating or drinking well. The physician will manage significant fluid and electrolyte imbalance, and associated risks, appropriately and in a timely manner. The staff will provide supportive measures such as supplemental fluids where indicated. Review of the policy Pain - Clinical Protocol revised March 2018 revealed with input from the resident to the extent possible, the physician and staff will establish goals of pain treatment. The nursing staff assess each individual for pain upon admission to the facility, at quarterly review, whenever there is a significant change in condition, and when there is a new onset of pain or worsening of existing pain. The physician will order pharmacologic interventions to address the individual's pain. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the policy Change in Resident's Condition or Status revised February 2021 revealed the facility promptly notifies the resident's physician when there has been changes in the resident's medical/mental condition and/or status, or there is a need to alter the resident's medical treatment significantly. This deficiency represents non-compliance investigated under Complaint Numbers OH00163018 and OH00162481

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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** 42011 Based on observation, interview, record review, and review of facility policy, the facility failed to obtain ordered laboratory testing to identify a urinary tract infection and failed to provide proper care and treatment for an indwelling urinary catheter to prevent urinary tract infections (UTI). This affected one resident (Resident #13) of one resident reviewed for a foley catheter. In addition, the facility failed to timely initiate treatment for a UTI for Resident #42. This affected one resident (#42) of four residents reviewed for medications. The facility census was 81. Findings include: Record review for Resident #13 revealed an admitted [DATE]. Diagnosis included cerebral infarction, neuromuscular dysfunction of the bladder (a problem in which the resident lacks bladder control), obstructive and reflux uropathy (backup of urine into the unilateral or bilateral kidneys, depending on the location of the obstruction, this can lead to potential kidney damage), muscle wasting and atrophy, and muscle weakness. Review of the care plan dated 07/24/24 revealed Resident #13 had an indwelling urinary catheter size 22 French related to obstructive uropathy, neurogenic bladder and urinary retention. Interventions included changing the foley catheter per the physician orders, maintaining infection control, and maintaining the urinary drainage bag below the bladder level. Review of the Modification of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 was cognitively intact. Resident #13 had impairment on both sides of the lower extremities, was dependent on staff for toileting hygiene, and required substantial/maximal assistants for personal hygiene. Resident #13 had an indwelling catheter and was always incontinent of bowel. Review of the previous UA C&S results for Resident #13 from 07/03/24 through 04/01/25 revealed the resident had a history of recurrent UTIs and was diagnosed with and subsequently treated for UTIs on 07/14/24, 08/05/24, and 02/01/25. Review of the Certified Nurse Practitioner (CNP) note dated 03/13/25 at 8:04 A.M. revealed Resident #13's daughter stated the resident was confused and for the last two days, the resident had not been herself. The resident was noted to be back to her baseline at the time of the note. The note referenced the plan for the resident's care was for nursing staff to continue current care, monitor the resident closely, and obtain a urinalysis (UA) with a culture and sensitivity (C&S) and labs. Review of the CNP progress note dated 03/18/25 at 8:18 P.M. for Resident #13 reported urinary pain and the listed plan included discussing with nursing staff for administration of pyridium (a medication used to decrease urinary pain) and obtaining a UA C&S. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note dated 03/20/25 at 6:57 A.M. authored by Licensed Practical Nurse (LPN) #254 for Resident #13 revealed the nurse and another unnamed nurse had attempted to change Resident #13's indwelling catheter but could not locate the proper sized catheter. A subsequent note timed 8:09 A.M. authored by Registered Nurse (RN) #301 revealed the resident's nurse practitioner had been contacted concerning the resident's urinary catheter and ordered the resident to be sent to the local emergency department. Review of the progress note dated 03/23/25 at 8:11 P.M. authored by RN #323 for Resident #13 revealed the resident returned from a local hospital on 03/23/25 at approximately 5:30 P.M. The resident had been hospitalized and treated for diagnoses of cystitis (bladder infection). Review of the hospital After Visit Summary from 03/20/25 through 03/23/25 for Resident #13 revealed the resident had been hospitalized for possible cystitis and UTI, and upon arrival had a malpositioned indwelling urinary catheter. The resident's urinary catheter was changed, and during the hospitalization she received intravenous antibiotics to treat her UTI. Review of the CNP progress note dated 03/24/25 at 1:19 P.M. authored by CNP #802 revealed Resident #13 returned from the local hospital on 03/23/25 where she had been treated for a UTI. The plan discussed with nursing staff stated to continue current care and to monitor the resident closely. Observation on 03/25/25 at 3:03 P.M. revealed Resident #13 was lying in bed. Resident #13's urinary catheter drainage bag was lying on the bed next to Resident #13's right leg. No staff were present in the room. The drainage bag was not positioned below the resident's bladder level. Observation and interview on 03/25/25 at 3:05 P.M. with RN #301 confirmed Resident #13 was lying in bed. Resident #13's urinary drainage bag remained positioned next to the resident's right leg, unchanged from the prior observation. RN #301 confirmed the urine was unable to flow freely by gravity due to the inappropriate placement of the urinary drainage bag. RN #301 revealed she had not been in Resident #13's room, so she dd not know why the bag was placed and left on the bed. Telephone interview on 03/26/25 at 11:09 A.M. with CNP #802 revealed the nursing staff never obtained the urine for the UA and C&S ordered on 03/13/25 or 03/18/25 for Resident #13, so she had the resident sent to the local emergency room for evaluation. The staff never explained to her why they did not obtain Resident #13's urinalysis per the orders. Resident #13 required the catheter due to a diagnosis of neurogenic bladder. CNP #802 revealed a urinary catheter drained the urine by gravity. CNP #802 stated urinary drainage bags must be kept below the bladder level for the urine to drain. If the urine cannot drain, urine could backflow and could grow bacteria and develop into a UTI. Observation in 03/27/25 at 11:43 A.M. revealed Resident #13 was seated in her tilt-back wheelchair in her room. The wheelchair was tilted back in a reclined position, and the urinary drainage bag was hanging on the armrest of the chair. The catheter bag was positioned above Resident #13's abdomen and above the bladder level. No staff were present in Resident #13's room. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 03/27/25 at 11:43 A.M. with LPN #304 verified Resident #13 seated in her tilt-back wheelchair in her room. The wheelchair was tilted back in a reclined position, and the urinary drainage bag was hanging on the armrest of the chair. The catheter bag was positioned above Resident #13's abdomen and above the bladder level. LPN #304 stated, I don't know how many times I have to tell them, thank you for telling me. LPN #304 confirmed she had found the catheter bag above Resident #13's bladder several times in the past. Review of the policy Supporting Activities of Daily Living (ADLs) dated March 2018 revealed appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care. 37096 2. Review of the medical record for Resident #42 revealed an admitted [DATE]. Diagnoses included sepsis, osteomyelitis, heart failure, dementia, and peripheral vascular disease. Review of the laboratory service report dated 03/06/25 at 10:11 A.M. revealed the urine culture resulted Escherichia coli and extended spectrum beta lactamase (ESBL) producing organism. The report revealed the organism was resistant to ciprofloxacin and sensitive to Macrobid. Review of the admitting medications reconciliation dated 03/06/25 revealed ciprofloxacin 250 milligram (mg) twice daily was crossed off not to be administered. Review of Resident #42's physician orders dated 03/06/25 at 6:13 P.M. revealed an order dated 03/08/25 for Macrobid 100 milligrams, an antibiotic, two times a day to treat urinary tract infection. Review of the nursing progress note dated 03/08/25 stated Macrobid oral capsule 100 mg by mouth two a day for Urinary tract infection (URI) was not available. Review of the starter kit replacement form dated 03/08/25 stated Macrobid 100 mg was pulled from the started kit to be administered. Moreover, there was no time stating the medication was pulled. Review of the Medication Administration Record (MAR) March 2025 revealed 03/08/25 Macrobid 100 mg was documented as not administered and to see nurses note. Macrobid 100 mg was administered 03/09/25 through 03/18/25. Review of the comprehensive Minimum Data Set 3.0 dated 03/12/25 revealed the resident had moderate cognitive impairment and was dependent on staff for toileting, transfers and ambulation. The assessment indicated the resident received an antibiotic and an antiplatelet. Interview on 03/31/25 at 10:09 at 12:05 P.M. with the Director of Nursing (DON) verified there was a delay in initiating treatment for Resident #42's UTI. The DON confirmed there was a lapse between when the urine culture resulted on 03/06/25 to when Resident #42 received her first dose of antibiotic therapy on 03/08/25.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37096 Based on record review and interview, the facility failed to apply Resident #179's Automatic Positive Airway Pressure (auto-PAP) machine as ordered. This affected one resident (#179) of four residents reviewed for respiratory care. The facility census was 81. Finding include: Review of Resident #179's medical record revealed an admitted [DATE] with diagnoses including respiratory failure, chronic obstructive pulmonary disease (COPD), obesity, and emphysema. Resident #179 was discharged on [DATE]. Review of the physicians order for February 2025 revealed an order for an auto-PAP (a respiratory machine worn while sleeping which provides positive airway pressure and automatically adjusts in response to measured airway resistance) to be applied every night and as needed for naps. Review of the Treatment Record (TAR) for February 2025 revealed the treatment was signed off on for evening on 02/19/25 and 02/20/25. Review of the nursing assessment dated [DATE] revealed Resident #179 was alert and orientated to person, place and time. The resident was recorded as independent with activities of daily living. Review of the progress note dated 02/11/25 at 11:00 P.M. revealed the Resident #179 had diminished lungs sounds and difficulty breathing. The Nurse Practitioner (NP) ordered to send Resident #179 to the emergency room (ER). A subsequent note dated 02/21/25 at 10:00 A.M. revealed Resident #179 was unresponsive and sent to the ER for further evaluation. Review of the hospital summary dated 02/13/25 revealed the resident had a history of severe COPD, chronic hypercapnic respiratory failure, history of pulmonary embolism, tracheobronchial malacia (a condition where to airway become soft and can collapse during breathing), and had numerous recent hospitalization s for respiratory failure. Review of a Self-Reported Incident (SRI) dated 02/21/25 revealed the facility self-reported an allegation of neglect. The facility Nurse Practitioner (NP) had reported that staff failed to follow treatment order for Resident #179's auto-PAP application. The witness statement for Licensed Practical Nurse (LPN) #351, recorded by the Administrator, stated LPN #351 was interviewed by telephone and was questioned regarding Resident #179's auto-PAP. LPN #351 stated she did not apply the auto-PAP at bedtime on 02/20/25. LPN #351 was unable to give any specific reason why the auto-PAP for Resident #179 was not applied per order other than she had forgotten to apply the resident's auto-PAP. The facility investigated the incident and concluded no neglect had occurred. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/01/25 at 10:28 A.M. with Registered Nurse (RN) #321 revealed she was assigned to Resident #179 the morning of 02/21/25. The resident was up and eating breakfast when she administered her morning medications. Approximately 40 minutes later, RN #321 stated she received a call from Resident #179's daughter who stated she had video-called Resident #179 and stated the resident did not look good. RN #321 assessed Resident #179, who had difficulty breathing. RN #321 applied the resident's auto-PAP and called emergency medical services (EMS) to transfer the resident to the local emergency room (ER) for further treatment. RN #321 did not receive any report from the night nurse that the resident had not had her auto-PAP applied as ordered the night before. Interview on 04/01/25 at 11:24 A.M. with Nurse Practitioner (NP) #352 stated it was reported to her that Resident #179 did not receive her auto-PAP treatment on the night of 02/20/25, and she reported it to the Administrator. Resident #179 was very sick and had horrible lungs. The resident had an extensive medical history, multiple respiratory conditions, and was intubated multiple times prior to admitting to the facility. NP #352 stated not receiving auto-PAP on 02/20/25 had no correlation with the resident being sent to the hospital on 02/21/25. Interview on 04/01/25 at 12:01 P.M. with the Administrator revealed the nurse verified the auto-PAP treatment was not applied overnight on 02/20/25. LPN #351 was an agency nurse was placed on 'do not return' status following the incident. This deficiency represents non-compliance investigated under Complaint Number OH00163179.

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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** 39969 Based on record review, interview, and review of facility policy, the facility failed to ensure pharmacy recommendations were addressed in a timely manner. This affected two residents (#10 and #28) of five residents reviewed for unnecessary medications and one resident (#42) of one resident reviewed for antibiotic use. The facility census was 81. Findings include: 1. Review of the medical record for Resident #10 revealed an admitted [DATE]. Diagnoses included vascular dementia and schizoaffective disorder. Review of the pharmacy progress notes revealed a pharmacy recommendation were made on 09/10/24 and 10/21/24. Review of the pharmacy recommendation dated 09/10/24 revealed federal regulation required a gradual dose reduction (GDR) attempt on psychotropic medication twice within the first year (in separate quarters) and then once annually thereafter, unless contraindicated. Cymbalta 60 milligrams (mg) twice daily was the listed medication for the recommendation. On the form, a handwritten X was written to indicate the dose reduction was clinically contraindicated. On the form, a handwritten X was written to indicate the resident's target symptoms returned or worsened after the most recent GDR attempt within the facility and a GDR attempt at this time is likely to impair the individual's function or cause psychiatric instability by exacerbating an underlying medical condition or psychiatric disorder. Printed in bold on the form was Please provide CMS Required patient specific rationale describing why a GDR attempt is likely to impair function or cause psychiatric instability in this specific resident. The recommendation was signed and dated 09/12/24. Noted on the bottom right corner of the recommendation was a statement the form was printed on 03/25/25. Interview on 03/31/25 at 2:02 P.M. with the Administrator revealed she was unable to locate the pharmacy recommendation for 10/21/24. Interview on 03/31/25 at 2:56 P.M. with the Director of Nursing (DON) verified there was no note in Resident #10's medical record documenting the rationale for the declination of a GDR for the Cymbalta. The DON also verified the recommendation was printed on 03/25/25 and signed with a date for 09/12/24. 2. Review of the medical record for Resident #28 revealed an admitted [DATE]. Diagnoses included morbid (severe) obesity due to excess calories, lymphedema, major depressive disorder, generalized anxiety disorder, muscle weakness, and acquired absence of right leg below knee. (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 pharmacy recommendation dated 08/12/24 revealed federal regulation required a GDR attempt on psychotropic medication twice within the first year (in separate quarters) and then once annually thereafter, unless contraindicated. Cymbalta 60 milligrams (mg) twice daily was the listed medication for the recommendation. On the form, a handwritten X was written to indicate the dose reduction was clinically contraindicated. On the form, a handwritten X was written to indicate the resident's target symptoms returned or worsened after the most recent GDR attempt within the facility and a GDR attempt at this time is likely to impair the individual's function or cause psychiatric instability by exacerbating an underlying medical condition or psychiatric disorder. Printed in bold on the form was Please provide CMS Required patient specific rationale describing why a GDR attempt is likely to impair function or cause psychiatric instability in this specific resident. The recommendation was signed and dated 08/14/24. Noted on the bottom right corner of the recommendation was a statement the form was printed on 03/25/25. Review of the pharmacy recommendations dated 10/20/24, 12/05/24, and 01/05/25 all three forms recommended adding laboratory testing for Resident #28. The form recommended an A1C (also known as glycated hemoglobin; used to measure the average blood sugar level the the past three months) level, a fasting lipid panel (FLP), thyroid-stimulating hormone (TSH) level, and a vitamin D level to the next lab draw day. All three agreements were marked agreed and signed by the provider. Interview on 03/31/25 at 1:44 P.M. with the Director of Nursing (DON) verified there was no rationale in Resident #28's medical record for declining the GDR for the Cymbalta. The DON stated the recommendation was a reprint on 03/25/25 and was signed and dated 08/14/24. The DON verified the pharmacy recommendations dated 10/21/24, 12/05/24, and 01/05/25 were all repeated recommendations to add laboratory testing. The DON stated she was unable to locate any prior laboratory testing having been completed for Resident #28 until the labs were drawn on 01/14/25. Review of the policy Medication Regimen Reviews, revised May 2019 revealed a consultant pharmacist will medication regimen reviews (MRR) upon admission and at least monthly thereafter. The MRR involves a thorough review of the resident's medical record to prevent, identify, report, and resolve medication related problems and other irregularities. An irregularity refers to the use of medication that is inconsistent with accepted pharmaceutical services standards of practice; is not supported by medical evidence; and/or impedes or interferes with achieving the intended outcomes of pharmaceutical services. It may also include the use of medication without indication, without adequate monitoring, in excessive doses, and or in the presence of adverse consequences. If the physician does not provide a timely or adequate response, he/she contacts the Medical Director or the Administrator. The attending physician documents in the medical record that the irregularity has been reviewed and what (if any) action was taken to address it. 37096 3. Review of the medical record for Resident #42 revealed an admitted [DATE]. Diagnoses included sepsis, osteomyelitis, heart failure, dementia, and peripheral vascular disease. Review of the comprehensive Minimum Data Set 3.0 dated 03/12/25 revealed the resident had moderate cognitive impairment and was dependent on staff for toileting, transfers and ambulation. The assessment indicated the resident received and antibiotic and antiplatelet. (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 Resident #42's physician orders revealed an order dated 03/08/25 for Macrobid 100 milligrams (mg), an antibiotic, administered two times a day to treat urinary tract infection (UTI). Review of progress note dated 03/08/25 at 6:30 P.M. revealed a new order was placed for Macrobid 100 mg to be administered twice daily for a duration of ten days to treat a UTI. The note stated the order was outside of the recommended dose or frequency. The dose failed a general dose range check, and the drug's dose should be adjusted based on renal function. The note concluded by noting manual screening was required. Additional review of Resident #42's progress notes revealed no evidence the resident's Macrobid dose had been reviewed or clarified with the resident's physician. Review of the Medication Administration Record (MAR) March 2025 revealed Macrobid 100 mg was administered twice daily as ordered from 03/09/25 through 03/18/25. Interview with the Director of Nursing (DON) on 03/25/25 confirmed the order was not addressed by the physician for proper dosing. Review of the facility policy titled Administering Medications revised April 2019 states if a dosage is believed to be inappropriate or excessive for a resident, Or a mediation has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person administering the medication will contact the prescriber.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, interview, and record review, the facility failed to ensure residents received meals compatible with their likes and dislikes. This affected one resident (Resident #22) and had the potential to affect 76 of 81 residents receiving food from the kitchen as five residents (Resident #17, #35, #44, #52, and #62) received nothing by mouth (NPO). The facility census was 81. Findings include: Record review for Resident #22 revealed an admitted [DATE]. Diagnosis included chronic kidney disease, gout, and type two diabetes mellitus. Review of the Annual Minimum Data Set (MDS) dated [DATE] revealed Resident #22 was cognitively intact. Resident #22's preferences were very important to him. Review of the care plan dated 03/06/25 revealed Resident (#22) is at risk for altered nutritional status related to: Diuretic use, abnormal labs, obesity, therapeutic diet needs, edema and weight changes. Interventions included to provide meals / snacks / fluids based on resident food preferences and physician orders. Review of the physician orders dated 06/04/24 revealed Resident #22's diet order was a two gram low sodium diet, regular texture, regular consistency low sodium diet; double protein/meat portions for nutrition. Review of the facility list of resident diets revealed Resident #17, #35, #44, #52, and #62 received nothing by mouth. Observation on 03/27/25 at 1:19 P.M. of the lunch meal revealed Resident #22 was served corn for his portion of vegetables. Resident #22 did not eat any of his corn. Resident #22 stated, They gave me corn, I told them over and over I don't like corn. Interview on 03/27/25 at 2:26 P.M. with Dietary Tech (DT) #401 confirmed Resident #22 received corn for his vegetable serving at lunch. DT #401 revealed food likes and dislikes were not updated in the new system they recently started. The ordered type and texture was available, but no likes or dislikes were available for any residents. Interview on 03/27/25 at 3:06 P.M. with Dietary Manager (DM) #211 revealed on 03/19/25 the previous contract company removed their software that included the residents food likes and dislikes. The system they had would automatically replace a residents dislikes with an alternate item of equal nutritional value that the resident liked. Since the company took the software on 03/19/25, the facility no longer had the information to include any of the residents food likes and dislikes. DM #211 revealed she had no way to retrieve the information other than to ask the residents again. DM #211 revealed she planned to start that next week.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 39968 Based on review of facility documentation and interview with the Administrator, the facility failed to provide a complete and detailed Facility Assessment. This had the potential to affect all 81 residents residing in the facility. Findings include: Review of the Enhanced Facility Assessment, reviewed and updated on 10/01/24 by the Administrator revealed the facility assessment did not identify all the personnel involved in the writing and approval process of the plan, the average census was not accurate, the average number of residents admitted and discharged in a day were not accurate, it did not include common diagnoses the facility admits, what kind of services or care offered, or details regarding staffing levels on each shift. Interview on 03/31/25 at 1:32 P.M. with the Administrator revealed she understood and agreed with the above discrepancies.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37096 Based on record review and interview the facility failed to ensure accurate documentation in the medical record. This affected two residents (Resident #42 and #179) of two residents reviewed for accuracy of medical records. The facility census was 81. Findings include: 1. Review of Resident #179's medical record revealed an admitted [DATE] with diagnoses including Respiratory failure, chronic obstructive pulmonary disease (COPD), obesity, and emphysema. Resident #179 was discharged on [DATE]. Review of the physicians order for February 2025 revealed an order for an auto-pap (auto-adjusted positive airway pressure) to apply as needed for naps and every night. Review of the Treatment Record (TAR) for February 2025 revealed the treatment was signed off on for evening on 02/19/25 and 02/20/25. Review of Self-Reported Incident (SRI) 257446 dated 02/21/25 revealed the Nurse Practitioner (NP) reported that staff failed to follow treatment order for Resident #179 auto-pap. The witness statement for Licensed Practical Nurse (LPN) #351 taken by the Administrator per phone stated the LPN #351 was questioned regarding the auto-pap stated she did not apply the auto-pap at bedtime on 02/20/25. LPN #351 was unable to give any specific reason why the auto-pap was not administered. Interview on 04/01/25 at 12:01 P.M. with the Administrator stated the nurse verified the auto-pap treatment was not applied on 02/20/25. LPN #351 was an agency nurse; the incident was reported to the agency and the nurse was put on a do not return status. The Administrator stated she did not know why LPN #351 signed off the treatment as administered. 2. Review of the medical record for Resident #42 revealed an admittance date of 03/06/25. Diagnoses included sepsis, osteomyelitis, heart failure, dementia, and peripheral vascular disease. Review of the comprehensive Minimum Data Set 3.0 dated 03/12/25 revealed the resident had moderate cognitive impairment and was dependent on staff for toileting, transfers and ambulation. The assessment indicated the resident received an antibiotic and antiplatelet. Review of Resident #42's physician orders dated 03/06/25 at 6:13 P.M. revealed an order dated 03/08/25 for Macrobid 100 milligrams, an antibiotic, administered two times a day to treat urinary tract infection. Review of the nursing progress note dated 03/08/25 stated Macrobid oral capsule 100 mg by mouth two a day for Urinary tract infection (URI) was not available. Review of the starter kit replacement form dated 03/08/25 stated Macrobid 100 mg was pulled from the starter kit to be administered but there was no time stating the medication was pulled. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Administration Record (MAR) March 2025 revealed Macrobid 100 mg was documented as not administered and to see nurses note. Interview on 03/31/25 10:50 A.M. with the Director of Nursing (DON) verified the antibiotic was pulled from the starter kit, however, there was no signature of the nurse pulling the medication or time the medication was pulled. The DON stated that the nurse should document in the progress note that the medication was administered. Interview at this time with Registered Nurse (RN) #257, the unit manager, stated the nurse told her that she did not have to document the medication she administered. Review of the policy titled Administering Medication dated April 2019 stated the individual administering the medication records in the resident's record the date and time the medication was administered.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on record review, interview, and review of the facility policy, the facility failed to offer the flu and or pneumonia vaccine for all residents. This affected four residents (Resident #9, #10, #13, and #21) of five residents reviewed for immunizations. The facility census was 81. Findings include: 1. Record review for Resident #21 revealed an admitted [DATE]. Diagnosis included functional quadriplegia, hemiplegia and hemiparesis, and encounter for attention to gastrostomy. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #21 was cognitively intact. Review of the immunization record for Resident #21 revealed the flu nor the pneumonia vaccine was neither offered nor refused for 2024 or 2025. Record review revealed no contraindication to the flu or pneumococcal vaccine. Interview and record review on 03/31/25 at 1:05 P.M. with Director of Nursing (DON) confirmed the flu nor the pneumococcal vaccine was neither offered nor refused for 2024 or 2025 for Resident #21. Interview on 04/01/25 at 11:15 A.M. with Resident #21 confirmed she was not offered the flu or the pneumococcal vaccine for 2024 or 2025. 2. Record review for Resident #9 revealed a readmitted [DATE]. Diagnosis included paraplegia, incomplete, anxiety disorder, and weakness. Review of the quarterly MDS dated [DATE] for Resident #9 revealed Resident #9 was cognitively intact. Review of the immunization record for Resident #9 revealed the pneumococcal vaccine was not offered nor refused for 2024 or 2025. The record did not indicate the last time the pneumococcal vaccine was received. Interview and record review on 03/31/25 at 1:06 P.M. with DON confirmed the pneumococcal vaccine was not offered nor refused for 2024 or 2025 for Resident #9. Interview on 04/01/25 at 11:20 A.M. with Resident #9 confirmed he was not offered the pneumococcal vaccine for 2024 or 2025. 3. Record review for Resident #13 revealed an admitted [DATE]. Diagnosis included cerebral infarction, muscle wasting and atrophy, and muscle weakness. Review of the Modification of the quarterly MDS dated [DATE] revealed Resident #13 was cognitively intact. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366114	A. Building B. Wing	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Lyndhurst	1575 Brainard Rd Lyndhurst, OH 44124

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the immunization record for Resident #13 revealed the pneumococcal vaccine was not offered nor refused for 2024 or 2025. The record did not indicate the last time the pneumococcal vaccine was received. Interview and record review on 03/31/25 at 1:07 P.M. with DON confirmed the pneumococcal vaccine was not offered nor refused for 2024 or 2025 for Resident #13. Interview on 03/31/25 at 3:05 P.M. with Resident #13 revealed she was not offered the pneumococcal vaccine for 2024 or 2025. 4. Record review for Resident #10 revealed an admitted [DATE]. Diagnosis included dysphagia, gastrostomy status, and vascular dementia. Review of the quarterly MDS dated [DATE] revealed Resident #10 was severely cognitively impaired. Review of the immunization record for Resident #10 revealed the flu nor the pneumonia vaccine was neither offered nor refused for 2024 or 2025. The record did not indicate the last time the pneumococcal vaccine was received. Record review revealed no contraindication to the flu or pneumococcal vaccine. Interview and record review on 03/31/25 at 2:18 P.M. with DON confirmed the flu nor the pneumococcal vaccine was neither offered nor refused for 2024 or 2025 for Resident #10. Review of the facility policy titled, Pneumococcal Vaccine revised October 2019 revealed all residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Review of the facility policy titled, Influenza Vaccine revised March 2022 revealed all residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccination against influenza.