STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366128	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altercare Cambridge Inc.	66731 Old Twenty-One Road Cambridge, OH 43725

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, hospital record review, Self-Reported Incident (SRI) review, facility policy review, and interviews, the facility failed to timely identify and address a resident's change in condition following a mechanical lift transfer. This affected one resident (#55) of three residents reviewed for hospitalizations. The facility census was 47. Actual harm occurred on 11/16/25 when Resident #55, who was severely cognitively impaired and required staff assistance for activities of daily living, slammed her body down into a sit-to-stand (mechanical lift) device on her right side and back due to an episode of increased weakness. The facility staff failed to notify the resident's medical provider of the change in condition including the episode of weakness and slamming of the right side of her body and back down into the sit-to-stand device. The resident was assessed at the time with no injuries noted. Following the initial assessment, there was no documented evidence of ongoing monitoring of the resident's right side and back for bruising or injury. The resident was admitted to the hospital on [DATE] (two days later) with diagnoses including traumatic hematoma of the right gluteal region, acute kidney injury likely due to hypovolemia as a result of extravasation (the accidental leakage of fluid from a blood vessel into surrounding tissue) of blood into the tissue, acute blood loss anemia, and severe anemia as a result of the sit-to-stand incident on 11/16/25. Findings include: Closed record review revealed Resident #55 was admitted to the facility on [DATE] with diagnoses including infection following a procedure surgical site, cellulitis of left lower limb, dementia, anemia, muscle weakness, dysphagia, cognitive communication deficit, repeated falls, fracture of left femur, and acute respiratory failure with hypoxia. Review of the admission Minimum Data Set (MDS) 3.0 revealed Resident #55 was severely cognitively impaired and required physical assistance from staff with activities of daily living (ADLs) and substantial/maximal assistance with sit-to-stand and chair/bed-to-chair transfer. Review of the care plan dated 10/21/25, revealed Resident #55 had anemia and was at risk for fatigue, weakness, and confusion. Interventions included observing the resident for the following signs and symptoms associated with anemia: pale skin, fatigue, shortness of breath, headaches, insomnia, dizziness, leg cramping, increased heartbeat and altered blood values such as low hemoglobin. Further review of the care plan revealed the resident was at risk for falls/injury related to confusion, history of falls, and incontinence of bowel and urine. Interventions included with device use, to observe for potential mental and physical side effects such as lethargy, mood changes, mobility changes, skin integrity changes, and toileting changes; and to report side effects to the physician or nurse practitioner (NP). Review of a facility Self-Reported Incident (SRI) tracking number 267738 submitted to the Ohio Department of Health (ODH) on 11/19/25 revealed an investigation was initiated by the facility following an allegation of possible physical abuse. The SRI revealed Resident #55 was discharged to the hospital on [DATE] following a non-SRI related critical lab finding. Resident #55's daughter contacted the facility on 11/19/25 to report the resident had bruising on her right hip and possibly small bruises on her back. There was no alleged perpetrator. Staff were interviewed and it was revealed that over the weekend, 11/15-11/16/25, staff had attempted to utilize a mechanical lift known as a sit-to-stand to safely transfer the resident. Staff stated Resident #55 demonstrated a noticeable right-side lean during this time and had to be highly (continued on next page)

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

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	encouraged to keep her feet in place. Staff stated the resident had rubbed her right hip area against the device on multiple occasions and leaned in the back support brace with most of her body weight. The night shift nurse and aide noticed a small quarter-sized reddened/pink area located on the right hip while providing care on the night of 11/17/25. On the morning of 11/18/25 preceding the resident's transfer to the hospital, the certified nursing assistant (CNA) notified the nurse on duty of the area as well, however, before she could be examined, the resident was sent to the hospital. The SRI included at no time did the resident voice concerns of pain or issues with the area. It was reported by staff that the resident demonstrated a right-side lean multiple times while transferring, causing the resident's hip to come into contact with the assistive device. The resident also put her full weight into the supportive sling that was wrapped around her back, which is the most likely explanation for the alleged bruising. The facility unsubstantiated the allegation of abuse. Review of a nursing progress note, 11/16/25 at 12:31 P.M., (authored by Licensed Practical Nurse (LPN) #318) revealed she was alerted by the CNA that Resident #55 appeared weak while utilizing the sit-to-stand device. Respirations were even and unlabored with respiratory rate of 18, pulse was 88, blood pressure was 124/75, oxygen saturation was 87% on room air. The resident was alert and oriented to self and surroundings and did mention to her spouse while visiting that she fell and was running around the facility all night, which she did not. She was easily reoriented and able to answer questions and express needs. She stated she just feels tired today. Review of a Treatment Administration Record (TAR), dated November 2025, revealed routine daily vital signs were ordered twice daily, on each shift. On 11/16/25 between 7:00 A.M. and 7:00 P.M., Resident #55's oxygen saturation level was 87%. Further review revealed the preceding daily oxygen saturation levels were between 94%-99%. There was no evidence documented in the medical record of physician notification of the change/abnormally low oxygen saturation level. Review of a nursing progress note dated 11/18/25 at 11:23 P.M., (authored by the Director of Nursing (DON) and recorded as a late entry on 11/24/25 at 10:39 A.M.) revealed per licensed practical nurse (LPN) interview, Resident #55 slammed her body down into sit-to-stand on her right side and her back during an episode of weakness. There were no noted injuries. The resident was safely transferred into bed and assessed thoroughly with no major obvious and/or findings. Upon documentation review it was noted that night shift LPN observed new bruising to the right hip area on 11/17/25. The area was identified as a clustered, small area of newer looking discoloration to the right side of hip area through the night by both CNA and LPN per completed pink man form. The area is consistent per interview with staff of resident bumping off sit-to-stand on Sunday evening. Further review of the medical record revealed no documentation of Resident #55 slamming into the sit-to-stand on 11/16/25 until 11/18/25 (recorded as late entry on 11/24/25 at 10:39 A.M.) when a nursing progress note was entered by the DON. Review did not reveal a nursing progress note regarding the newly identified bruising to the right hip on 11/17/25, described as a clustered small area of newer looking discoloration to the right side of hip area, as referenced in the 11/18/25 nursing progress note authored by the DON. Review of the Illustration of Documentation and Measurements of Skin Areas (Pink Man Form), dated 11/17/25, revealed a small circle drawn on the posterior right hip area. There was no documentation of measurements. Review of Resident #55's laboratory results collected on 11/17/25 revealed an abnormally low hemoglobin level of 6.9 grams per deciliter (g/dL) (normal range 11.7-15.8 g/dL). The Nurse Practitioner (NP) was notified on 11/18/25 and gave the order for the resident to be transferred to the emergency department (ED). Review of Resident #55's preceding hemoglobin levels were 9.2 g/dL on 10/31/25; 9.0 g/dL on 10/13/25; and 8.8 g/dL on 10/10/25. Review of Resident #55's hospital records revealed she arrived at the emergency department on 11/18/25 at 9:14 A.M. with diagnoses of acute blood loss, severe anemia, traumatic hematoma of hip, and acute kidney injury. The resident was found to have a hemoglobin of six (6) and was transfused with one unit of packed red blood cells. Her hemoglobin the next morning was 7.2 and therefore she was scheduled for two more units of packed red blood cells. The record noted a repeat computed tomography (CT) scan of the pelvis would be completed to (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	assess for any further worsening of the hematoma, which may warrant a transfer for angiogram and embolization if indicated. The plan was to transfuse to maintain hemoglobin above 8 and monitor hemoglobin and hematocrit every six hours. Surgery would be involved if there is no improvement after the transfusions, and/or the resident may be transferred out to have angiography for subsequent embolization if there was a persistent bleed. Acute kidney injury was noted to be likely due to hypovolemia as a result of the extravasation of blood into the tissue. The hospital record noted would avoid all nephrotoxins and maintain patient on intravenous (IV) fluid hydration to get off the blood transfusion and would be repeating labs in the morning to assess for correction of the renal function. The patient has Alzheimer's dementia and is disoriented with her surroundings. The hospital records revealed fall precautions would be maintained. Interview on 12/29/25 at 2:01 P.M. with Resident #55's daughter confirmed her mother had sustained traumatic bruising (in November 2025) to her entire right buttock area requiring the transfusion of three units of blood. The resident subsequently had fluid overload and was transferred to a Columbus area hospital to receive a higher level of care and received diuretics and treatment for congestive heart failure likely caused from the blood transfusions. The resident did not require surgical intervention. Interview on 12/23/25 at 4:33 P.M. with the DON revealed she first became aware of an issue after Resident #55's daughter called her on 11/19/25. The resident had been transferred to the hospital on [DATE] due to a very low hemoglobin level. Resident #55's daughter reported her mom had a large, bruised area to the right buttock and back. After interviews with staff, the DON concluded during an episode of weakness on 11/16/25 while being transferred with a sit-to-stand, Resident #55 sustained an injury/bruising. The DON stated following this incident, a Sara Steady Sit-to-Stand was utilized to transfer the resident due to increased weakness. The DON confirmed following the incident on 11/16/25 which was identified as the root cause of the resident's injury, there was no evidence of ongoing monitoring of the resident's right side or back, nor physician notification of the episode of weakness/incident. The DON revealed she believed a small bruise was initially identified on night shift, 11/17/25, but there was no evidence of physician notification. The DON further confirmed the facility did not investigate the resident's allegation made on 11/16/25 of a fall the night before as documented in the nursing progress note. Interview on 12/23/25 at 12:31 P.M. with Nurse Practitioner (NP) #401 revealed she did not recall being notified at the time of the incident on 11/16/25 when Resident #55 had an episode of weakness and slammed into the sit-to-stand; however, she was notified of the incident later in the week when the resident had an episode of weakness/pallor and slurred speech. NP #401 stated at this time she ordered lab work including a hemoglobin level to be obtained. Interview with Licensed Practical Nurse (LPN) #318 on 12/23/25 at 5:08 P.M. revealed she was notified by CNA #363 that Resident #55 was weak during a transfer with a sit-to-stand and fell against the device bumping her right side. The LPN revealed the resident's vital signs were stable other than her oxygen saturation which was 87% on room air. LPN #318 stated Resident #55 did not complain of pain or injury. LPN #318 confirmed she did not notify the physician of the incident or of the low oxygen saturation level of 87%. LPN #318 stated she believed she rechecked the oxygen saturation level later and it had come up, however, she did not document this reading. Review of the facility's policy titled, Change in the Residents Condition or Status, dated 05/01/25, revealed it was the facility's policy to ensure the resident's attending physician and the resident's authorized representative or interested family member were notified of changes in the resident's physical, mental, or psychosocial status. The nurses would immediately notify the resident, consult with the resident's attending physician, on-call physician, nurse practitioner, physician assistant, or clinical nurse specialist and notify resident's authorized representative when there was an accident or incident involving the resident, which resulted in an injury and had the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status. Procedure for documentation of changes in the medical record: the nurse would record in the resident's medical record information relative to changes in the resident's medical/mental condition or status (e.g. assessment, appropriate notifications, interventions, and responses).

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, hospital record review, policy review and interview, the facility failed to implement a comprehensive and individualized pressure ulcer program to timely identify, treat and/or prevent a decline of pressure ulcers. This affected two residents (Resident #42 and #07) of three residents reviewed for pressure ulcers. Actual Harm occurred on 12/06/25 when Resident #42, who had been identified at risk for pressure ulcer development and required maximum staff assistance for bed mobility, returned from the hospital with a red and blanchable area to his (unidentified) buttock without evidence of a comprehensive skin assessment or implementation of pressure relieving interventions or wound treatment to prevent decline in the pressure ulcer. On 12/11/25, a skin assessment identified a new Stage III (Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed) pressure ulcer to the coccyx without implementation of pressure relieving intervention until 12/15/25 (a low air loss mattress). Findings include: 1. Medical record review revealed Resident #42 was admitted to the facility on [DATE] with diagnoses including muscle weakness, polymyalgia rheumatica, atrial fibrillation, heart failure, chronic obstructive pulmonary disease, peripheral vascular disease, chronic ulcer of lower leg, venous insufficiency, hypothyroidism, type 2 Diabetes Mellitus, malnutrition and cognitive communication deficit. Review of Resident #42's Minimum Data Set (MDS) assessment completed on 10/21/25 revealed a Brief Interview for Mental Status score of 14 out of a possible 15 points, indicating the resident had intact cognition. The resident used a walker for mobility. Resident #42 was dependent on staff for toileting, lower body dressing, and transfers. He required substantial/ maximal (staff) assistance for bed mobility, including rolling in bed, showering, and dressing. The resident was frequently incontinent with bowel and bladder. Under Section M for skin conditions it was noted the resident had unhealed pressure ulcers/injuries. The resident required pressure reducing devices for bed, applications of ointments/ medications other than to the feet and dressings applied to the feet. The resident had one unstageable deep tissue injury noted on the assessment. Review of the resident's care plan dated 10/21/25 revealed Resident #42 has a pressure injury to his left heel with shearing and friction concerns, and poor sensory perception. The goal developed was for the resident's wound to show progressive signs of healing by target date of 01/21/26. Interventions included continuing with preventative care plan (there was no preventative care plan located as part of the medical record) measures to prevent further skin breakdown, nutritional status assessments as needed, observe wound for any redness, warmth, drainage, odor, and report to physician as needed. Further review of the medical record revealed the resident was admitted to the hospital on [DATE] with a diagnosis of weakness. The resident returned to the facility on [DATE]. Review of the hospital records revealed no mention of wounds to the resident's coccyx or buttocks. Chronic wounds to the right extremity and left heel were noted.Further review of Resident #42's medical record revealed a progress note authored by Licensed Practical Nurse (LPN) #344 on 12/06/25 at 4:04 P.M. and edited on 12/07/25 at 11:23 A.M. which documented the resident returned to the facility from the hospital. Assistant Director of Nursing (ADON) was made aware of the resident's arrival at the facility. Skin assessment completed upon arrival and noted resident had an area to his upper right shin and left heel (previously identified before hospitalization) and redness to his (unidentified) buttock but was blanchable with scattered bruising to all his body from recent hospital stay. The progress note revealed to See wound grids for noted areas (however, there were no skin grids completed by LPN #344 for the buttock). There was no mention of additional wounds to the buttocks or coccyx.Further review of the medical record revealed no documentation of physician notification related to the resident's red, blanchable area to his coccyx or buttocks. In addition, there was also no notification in the on-call physician notification notebook (kept at the nurses' station).Further review of the medical record revealed no evidence of any risk for pressure ulcer development care plan or mention of the (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	resident's pressure ulcers/injuries to his buttocks or coccyx.Review of weekly skin checks for Resident #42 revealed a skin check completed on 12/11/25 by LPN #344 stating a new area to the coccyx was identified. Assistant Director of Nursing (ADON) notified. No additional assessment was provided.Review of Resident #42 orders revealed an order dated 12/11/25 to cleanse the sacrum with soap/water, pat dry, apply Triad Paste (a zinc oxide based, sterile, hydrophilic wound dressing used for mild to moderate exudate (drainage) that creates a moist wound environment that facilitates natural debridement and protects the skin, especially in areas difficult to apply a dressing) twice a day (BID) and as needed (PRN) every shift.Review of Resident #42's wound management detail report revealed an assessment created and completed by the ADON on 12/13/25 and made a late entry for 12/06/25 (a seven day delay) revealed a wound to the sacrum measuring 4.2 centimeters (cm) in length, 5 cm in width, 0.1 cm in depth., Stage III (Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed. Slough (dead tissue) may be present but does not obscure the depth of tissue loss. May include undermining and tunneling (pockets or narrow passages under the skin)). Review of Wound Care Physician #404s progress note dated 12/11/25 revealed a stage III pressure wound to the sacrum, full thickness, measuring 8.5 cm by (x) 9 cm x 0.2 cm. Open ulceration area of 45.9 cm squared, light serous drainage, no pain, no signs of infection.Review of Resident #42's wound management detail report revealed an assessment created and completed by ADON on 12/13/25 and made a late entry for 12/11/25 (three-day delay) revealed a wound to the sacrum measuring 8.5 cm in length, 9 cm in width, 0.2 cm in depth., Stage III.Review of the Treatment Administration Record (TAR) for December 2025 revealed the Triad Paste treatment was initiated on 12/11/25.Review of Resident #42 orders revealed an order placed on 12/15/25 for a low air loss mattress, check functioning each shift three times a day (TID).Review of the December 2025 TAR revealed the low air loss mattress was implemented on 12/15/25.Review of Resident #42's wound management detail report revealed an assessment created and completed by ADON on 12/18/25 revealed a wound to the sacrum measuring 0.5 cm in length, 1.2 cm in width, 0.2 cm in depth., Stage III. The wound had light, clear drainage with pink, well defined wound edges. Review of Resident #42's record revealed no documentation of the resident refusing interventions including weight shifts, turning and repositioning, or treatments.Observation of wound care on 12/23/25 at 3:02 P.M. with ADON and Registered Nurse #403 revealed Resident #42 had an open area to his right buttock measuring 7.5 cm in length and 2.5 cm in width. The wound had no drainage and the wound bed was pink. The ADON stated that the wound had moved down further (the wound increased in size) since last Thursday (12/18/25). The ADON cleansed the area with soap and warm water, patted dry, and applied Triad Paste. Interview with the resident revealed he was unable to recall how long he had the pressure wound but he was currently getting treatment to the wound. The resident provided no additional information. Interview with Registered Nurse #314 on 12/24/25 at 7:36 A.M. revealed when a resident returns from the hospital, whether it's an admission or re-admission, it is always treated like an admission. First the nurse checks their medications, gets a second nurse to check off the medications, contacts the provider, asks the resident questions and completes a head-to-toe assessment which includes a skin assessment. Everything the nurse does was to be documented such as assessments of new wounds, skin changes even if it's bruising from Intravenous catheters (IV's), everything was documented. Skin assessments when a resident was admitted or returned can be found in the body of the admission note, which was in the progress notes. Any new skin abnormalities were measured, and a wound grid was created. If a resident's skin was red and blanchable, they would initiate interventions immediately to prevent it from deteriorating and opening. Wound rounds were completed once a week; the nurse should assess skin changes and document them. Wounds may be assessed more frequently, depending on the order, severity, changes in the wound, etc With any new skin issues, you are to notify the physician. If there was a new skin issue, for example red and blanchable but not open, med one (on-call physician notification) would be notified. Immediate interventions were initiated such as Triad paste and border foam dressing. Skin (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	interventions to prevent new or worsening areas begin on admission, and/or readmission.Interview with Wound Care Physician #404 on 12/24/25 at 10:03 A.M. revealed. Wound Care Physician #404 sees patients at the facility on Fridays and takes measurements but he was not aware of any open areas to the resident's skin until 12/11/25. Wound Care Physician #404 stated he recommended a low air loss mattress for Resident #42 on 12/11/25 because one was not already in place. Further interview revealed he was unsure of the resident's additional pressure prevention interventions but due to the resident already having one pressure ulcer and a wound to his leg, in addition to the resident's impaired mobility, he would have expected the resident to have had interventions in place.Interview on 12/24/25 at 12:46 P.M. with the ADON revealed she was responsible for overseeing pain management, restorative nursing services, wounds, and bowel and bladder incontinence. If a resident had (skin) redness, depending on where the redness was located, the resident should have preventatives (interventions) like extra protective cream (EPC) or a foam dressing, floating their heels, pressure reduction (devices) or Triad paste. The ADON further stated the treatment would depend on the location of the pressure area and the resident's mobility patterns (requiring staff assistance) with pressure and diabetic wounds being referred to the wound physician (Wound Care Physician #404).Further interview revealed Resident #42 was a re-admission and the admitting nurse completed a skin assessment, and she (the ADON) did a follow up skin assessment to the admission skin assessment. The ADON stated Resident #42 returned to the facility on [DATE] (Saturday) but she was not working that day and did not assess the wound until 12/08/25. The ADON verified the wound assessment for this wound was created by the ADON on 12/13/25 but back dated to reflect it was completed on 12/06/25, however, the ADON did not work on 12/06/25. The ADON did not provide additional information as to why the assessment was incorrectly dated 12/06/25 or why it was not consistent with LPN #344's findings (the hospital record also did not indicate the resident had any pressure ulcers or injuries to his coccyx or buttocks at the time of discharge back to the facility). The ADON shared the resident had two areas on his buttock that were red and open and she documented the areas were a Stage II (please note, the ADON did not identify the resident had two areas on his buttock and identified the area as a Stage III on the initial assessment). Wound Care Physician #404 evaluated the resident on 12/11/25 and determined the wound to the resident's sacrum was a Stage III. The ADON confirmed she only had her paper wound documentation for 12/08/25 that was for her personal tracking and not part of the resident's medical record. The ADON also confirmed there were no treatments ordered until the resident was seen by the wound physician on 12/11/25 despite her knowledge of the wound on 12/08/25 because she knew the physician would give orders when he visited on 12/11/25. The ADON verified she did not enter the order for the low air loss mattress that the wound physician ordered on 12/11/25 because she forgot and said looking back she should have gotten orders to start treatment to the resident's wound before the wound physician visited and per the documentation, the resident's wound declined without evidence of appropriate treatment and timely interventions.Interview on 12/24/25 at 1:03 P.M. with Regional Nurse #400 and #403 verified there were no interventions ordered or implemented until 12/11/25 for Resident #42's altered skin integrity. The Regional Nurses verified two skin grids were dated 12/06/25, one for the red and blanchable area and one for the Stage III pressure ulcer/injury to the sacral/coccyx area.Interview on 12/24/25 at 1:10 P.M. with the Director of Nursing (DON) confirmed Wound Care Physician #404 recommended a low air loss mattress on 12/11/25 for Resident #42; however there was no documentation or evidence the resident received the low air loss mattress until 12/15/25.Four unsuccessful interview attempts were made to contact LPN #344 by phone during the time of the survey from 12/22/25 through 12/24/25. Review of facility policy titled pressure injuries: assessment, prevention, and treatment revised 5/01/25 revealed it was the facilities policy to identify residents at risk for developing pressure injuries, implement interventions to prevent the development of pressure injuries and provide care for existing pressure injuries. A pressure injury risk assessment would be completed upon admission, quarterly, annually, and with significant change (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	period skin would be assessed routinely for the presence of developing pressure injuries and documented on the nursing skin tool. Interventions for prevention based on risk factors can include checking the residents for incontinence at least every two hours, cleaning the skin when soiled, using a moisture barrier, encouraging residents to shift weight every 15 minutes while sitting in a chair, use the pressure redistribution mattress, and use pillows or wedges and other devices for positioning. A Stage 3 pressure injury was defined as a full thickness skin loss in which adipose is visible in the ulcer and granulation tissue and rolled wound edges are often present. Slough or eschar may be visible. The depth of the tissue damage varies by anatomical location, areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and or bone are not exposed if slough or eschar obscures the extent of tissue loss this is an unstageable pressure injury. For provisions orders treat the wound per physician orders, protect the wound, manage drainage, promote A moist wound healing, and manage pain.2. Record review revealed Resident #07 admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left side, flaccid hemiplegia affecting left side, muscle weakness, abnormal posture, muscle wasting, diabetes mellitus, insomnia, hyperlipidemia, anxiety, vascular dementia, wheelchair dependent, bipolar disorder, contracture of left lower extremity and left upper extremity, and vascular dementia. Review of resident #07 quarterly Minimum Data Set (MDS) completed 10/28/25 revealed a BIMS score of 05, indicating severe cognitive impairment. The resident used a wheelchair and was dependent of staff for activities of daily living. The resident was also identified at risk for pressure ulcer development and required a pressure relieving device to the bed and chair.Review of Resident #07 skin tool completed on 12/20/25 completed by Registered Nurse #309 revealed the resident had no new areas of concern. Review of the resident's medical record revealed no current wound care orders.On 12/23/25 at 2:12 P.M. incontinence care was observed being performed on Resident #07 with the assistance of Regional Registered Nurse (RN) #403. Observation revealed scattered areas on Resident #07 bilateral buttock with scabbing, open areas, and blanchable tissues. All areas confirmed by Regional RN #403 on 12/23/24 at 2:15 P.M.Interview on 12/24/25 at 1:03 P.M. with Regional Nurse #400 and #403 confirmed Resident #07 had areas of impaired skin integrity that were not timely identified by staff resulting in delayed treatment to the wounds.Review of facility policy titled change in resident condition or status revised on 05/01/25 revealed it was policy to ensure the resident's attending physician, representative were notified of changes in the residence physical, mental, or psychosocial status. Nurses would immediately notify the resident, consult with resident's attending physician, or on call physician, nurse practitioner when there is a significant change in the residence physical, mental, or psychosocial status such as a deterioration health, mental, or echo social status and either life threatening condition or clinical complications. Documentation of changes in the medical record include the nurses recording in the resident's medical record information relative to changes in the resident's medical or mental condition or status such as assessments, appropriate notification, interventions, and response.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Review of the medical record, review of the facility policy, and interview with staff the facility failed to ensure as needed psychotropic medications were not used beyond 14 days without rationale. This affected two residents (#1, #51) reviewed for unnecessary medications. Findings include:1.Review of the medical record revealed Resident #1 was admitted to the facility on [DATE]. Diagnoses included sepsis, pneumonia, dysphagia, end stage renal disease, chronic respiratory failure with hypoxia, congestive heart failure, hypertension, rheumatoid arthritis, macular degeneration, vitamin D deficiency, exocrine pancreatic insufficiency, depression, hypertensive heart, chronic kidney disease, osteoarthritis, and atrial fibrillation. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had intact cognition, had no behaviors, and was not on any antipsychotic medications. Review of the December 2025 physician's orders revealed Resident #1 had an order for lorazepam (benzodiazepine used to treat anxiety) 0.5 milligram twice daily for anxiety as needed dated 11/20/25 with no rationale. Review of the Note to the Attending Physician (pharmacy recommendation) dated 12/10/25 revealed Resident #1 was currently receiving lorazepam 0.5mg twice daily as needed for longer than 14 days. If the medication was needed to be extended please document the rationale for the extended period in the medical record and indicate a specific duration. The note was signed by the nurse practitioner on 12/22/25. On 12/22/25 at 2:43 P.M. an interview with the Director of Nursing)DON) verified Resident #1 was receiving lorazepam for longer than 14 days without a stop date or rationale. Review of the facility policy titled, Psychoactive Medication, dated 05/01/25 revealed it was the policy of the facility to utilize psychoactive medication therapy to assist a resident to reach his/her highest practicable level of well-being. The facility would limit psychoactive medication use to circumstances in which the resident had a medical diagnoses and/or symptoms that warrant the use of therapeutic psychoactive medication. As needed orders for psychotropic drugs were limited to 14 days. If the practitioner believed that it was appropriate for the as needed order to be extended beyond 14 days he or she should document their rationale in the resident's medical record and indicate the duration of the as needed order. 2. Review of the medical record revealed Resident #51 was admitted to the facility on [DATE]. Diagnoses included metabolic encephalopathy, streptococcal infection, contusion of left thigh, dysphagia, cognitive communication deficit, congestive heart failure, urinary tract infection, chronic obstructive pulmonary disease, atrial fibrillation, chronic kidney disease, atherosclerotic heart disease, hypothyroidism, depression, hyperlipidemia, hypertension, panic disorder anxiety disorder, goiter, fracture of right pubis, and low back pain. Review of the December 2025 Physician's orders revealed Resident #51 had an order for lorazepam 0.5 milligrams every four hours as needed for terminal restlessness dated 12/01/25. Resident #51 was not receiving hospice services. On 12/22/25 at 2:43 P.M. an interview with the Director of Nursing verified Resident #51 was on lorazepam for longer than 14 days without a stop date or rationale.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, self-reported incident (SRI) review, facility investigation review, facility policy review, and interview, the facility failed to complete a thorough investigation following an allegation of abuse. This affected one (#55) of one resident reviewed for abuse. The facility census was 47.Findings include: Review of the Self-Reported Incident (SRI) #267738 submitted to the Ohio Department of Health (ODH) on 11/19/25 revealed an investigation was initiated by the facility for an allegation of physical abuse. The SRI revealed Resident #55 was discharged to the hospital on [DATE] following a non-SRI related critical lab finding. Resident #55's daughter contacted the facility on 11/19/25 to report the resident had bruising on her right hip and possibly small bruises on her back. There was no alleged perpetrator. Staff were interviewed and it was revealed that over the weekend 11/15-11/16/25 staff had attempted to utilize a mechanical lift known as a sit-to-stand to safely transfer the resident. Staff stated Resident #55 demonstrated a noticeable right-side lean during this time and had to be highly encouraged to keep her feet in place. Staff stated the resident had rubbed her right hip area against device on multiple occasions and leaned in the back support brace with most of her body weight. The night shift nurse and aide noticed a small quarter-sized reddened/pink area located on the right hip while providing care on the night of 11/17/25. On the morning of 11/18/25 preceding the resident's transfer to the hospital, the certified nurse aide (CNA) notified the nurse on duty of the area as well, however, before she could be examined, she was sent to the hospital. At no time did the resident voice concerns of pain or issues with the area. It was reported by staff that the resident demonstrated a right-side lean multiple times while transferring, causing the resident's hip to come into contact with the assistive device. The resident also put her full weight into the supportive sling that was wrapped around her back which is the most likely explanation for the alleged bruising. The facility unsubstantiated the allegation of abuse. Review of the medical record for Resident #55 revealed an admission date of 09/24/25 with diagnoses including infection following a procedure surgical site, cellulitis of left lower limb, muscle weakness, dysphagia, cognitive communication deficit, repeated falls, fracture of left femur, acute respiratory failure with hypoxia, anemia, and anxiety. Review of the Minimum Data Set (MDS) 3.0 revealed the resident was severely cognitively impaired and required physical assistance from staff with activities of daily living (ADLs). Review of the facility's investigation revealed Licensed Practical Nurse (LPN) #334, Certified Nursing Assistant (CNA) #303 and CNA #358's witness statements did not indicate dates or times of the referenced incident in their statements; CNA #358's witness statement (conducted via phone by the Director of Nursing) did not contain her last name or title; there was no witness statement obtained from CNA #367 who was identified by the DON as one of the two staff present during Resident #55's sit-to-stand incident; and no physical assessments for abuse were conducted of non-interviewable residents. Interview on 12/29/25 at 9:51 A.M. with the Director of Nursing (DON) confirmed the investigation of SRI #267738 did not contain witness statements for LPN #334 and CNA (#303 and #358) with a date of the incident referenced in the statements; and CNA #358's witness statement (conducted via phone by the Director of Nursing) did not contain her last name or title. The DON further confirmed there was no witness statement obtained from CNA #363 who was present during the identified incident which resulted in Resident #55's injury; and there were no observations or physical assessments for abuse of non-interviewable residents. Interview on 12/29/25 at 10:55 A.M with the Administrator confirmed the investigation for SRI #267738 did not contain witness statements with complete names and titles of all staff interviewed and dates of the information referenced in the witness statements. The Administrator further confirmed there was no evidence or documentation of non-interviewable residents having been physically assessed for abuse. Reviewed facility policy, Abuse, Mistreatment, Neglect, Misappropriation of Resident Property and Exploitation, undated, revealed the facility will not tolerate abuse, neglect, misappropriation of resident property or (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	exploitation of its residents. Once the Administrator and ODH are notified, an investigation of the allegation or suspicion will be conducted. Investigation protocol: interview the resident, the accused, and all witnesses. Witnesses generally include anyone who witnessed or heard the incident; came in close contact with the resident the day of the incident; and employees who worked closely with the accused employee and/or alleged victim the day of the incident. Obtain written statements from the resident, if possible, the accused, and each witness.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview, the facility failed to provide a person-centered, comprehensive care plan, developed and implemented to meet the preferences and goals, and address the resident's medical, physical, mental and psychosocial needs. This affected two residents (#37, #48) of five residents reviewed for care plans. The facility census was 47.Findings include:1. Review of the medical record for Resident #37 revealed she was admitted to the facility on [DATE]. Diagnoses included osteomyelitis; muscle weakness; need for assistance with personal care; methicillin resistant staphylococcus aureus; bacteremia; noncompliance with other medical treatment and regimen; Type 2 diabetes mellitus with diabetic polyneuropathy; depression; chronic obstructive pulmonary disease; anxiety disorder; hyperlipidemia; hypokalemia; anemia; acute kidney failure; hyperglycemia; and gastroesophageal reflux disease without esophagitis. Review of a Minimum Data Set (MDS) version 3.0, dated 11/18/25, for Resident #37 revealed a Brief Interview for Mental Status (BIMS) assessment score of 12 on a 0-15 scale. A score of 12 would indicate moderate problems with thinking and memory. The resident was to be non-weight bearing on the right foot, and required assistance with activities of daily living. Review of a care plan for Resident #37, dated 12/18/25, indicated the resident had an infection related to osteomyelitis of the right ankle. Interventions included providing medications as ordered. The care plan revealed the resident had a wound vacuum (or wound vac, a device which used negative pressure to accelerate wound healing and improve outcomes), which she frequently changed the rate on as a concern for healing of the chronic wound. There was a problem listed on care plan for behavioral symptoms. This problem included non-adherence to care/services which included noncompliance with changing settings on a wound vac, pulling tubes out of the wound vac, blaming the cat for changing the wound vac settings, noncompliance with keeping clothes on, constantly picking at wound vac dressing, yelling and cussing on phone and crawling around on the floor. Interventions for this included obtaining a psychological consult as needed and providing alternatives to refusals of care. Further review of the care plan for Resident #37 failed to reveal a problem statement or interventions for care and maintenance of a peripherally inserted central catheter (PICC). It also failed to reveal a problem for behavioral concerns regarding illegal drug use or mental health concerns. On 12/22/25 at 12:28 P.M., an observation of Resident #37 revealed a PICC line inserted into her right arm. The resident did not have a wound vac in place. This was confirmed by Registered Nurse (RN) #314 on 12/23/25 at 3:30 P.M. On 12/23/25 at 3:30 P.M., an interview with Registered Nurse (RN) #314 revealed the resident was no longer receiving intravenous antibiotics, however she still had a PICC line, which had been used for lab work and kept in place until the resident went to the Infectious Disease practitioner to see if she would require further intravenous antibiotics. She confirmed there had been no orders to discontinue use or care of PICC line. She further confirmed the resident no longer had orders for use of a wound vac. She reported the resident had been caught a few times with drug paraphernalia, and other smoking implements in her room, and was very disruptive to the entire hall. Review of a progress note, dated 12/13/25 at 7:30 A.M., was entered into Resident #37's chart on 12/15/25 at 1:58 P.M. The note indicated the staff found three pipes with an unknown substance in them wrapped in tissue in the resident's recliner. The resident was noted to appear under the influence of drugs or over medicated. The police were called and took the pipes and a report was filed. This was confirmed by Registered Nurse (RN) #336 on 12/24/25 at 10:48 A.M. An interview with RN #336 on 12/24/25 at 10:48 A.M., revealed Resident #37 had brought what they believed to be drugs into the facility or would sit with significant other across the street from the facility for long periods of time, smoking and possibly using other drugs. The facility had drug tested her and these tests came back positive. Because of this, her pain medications had been adjusted to non-narcotic pain medications. An interview with (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse (RN) #400 on 12/29/25 at 1:00 P.M. revealed Resident #37 had a care plan which did not address PICC line maintenance, drug use, or other behavioral issues which could be detrimental to her health and well-being. She also confirmed the care plan continued to list a wound vac as a problem, however the wound vac had been discontinued. 2. Review of medical record for Resident #48 revealed she was admitted on [DATE]. She had diagnoses of metabolic encephalopathy, sepsis, muscle weakness, acute on chronic diastolic congestive heart failure, chronic obstructive pulmonary disease, paroxysmal atrial fibrillation, hypothyroidism, unspecified bilateral hearing loss, anemia, and depression. Review of a Minimum Data Set (MDS) version 3.0 for Resident #48 dated 11/05/25 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 10 on a 0-15 scale. A score of ten indicated moderate problems with thinking and memory. Review of a care plan dated 12/22/25 revealed Resident #48 had an alteration in hearing but did not wear any hearing aides. There was no evidence in the review of the care plan to address Hospice or palliative care for the resident. Review of the medical record for Resident #48 failed to reveal an order for Palliative Care to begin. The first progress note from palliative care was noted on 01/02/25 and continued through 12/05/25. An interview with Registered Nurse (RN) #400 on 12/29/25 at 1:00 P.M. revealed Resident #48 was active with a Palliative Care agency. She confirmed the resident's record did not have orders or care plan for Palliative care. Review of a facility policy, dated 05/01/25, titled Care Planning-Comprehensive, revealed the facility's interdisciplinary team was responsible for care planning. The team would develop an individualized, comprehensive plan for each resident. Per the policy, care plans were to be updated as a resident condition changed. These plans were reviewed quarterly or when a significant change in condition in which a Minimal Data Set (MDS) assessment was completed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, medical record review and review of facility policy, the facility failed to ensure medications were properly stored. This affected one resident (#27) of one resident reviewed for medication storage. The facility census was 47.Findings include:Review of the medical record for Resident #27, revealed an admission date of 08/19/21. Diagnoses included: spinal stenosis, lumbar region without neurogenic claudication, Alzheimer's disease, dementia and major depressive disorder.Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 14. Observation on 12/22/25 at 10:23 A.M. revealed a medicine cup containing four pills on Resident #27's bedside table. Resident #27 stated she does not know how long they have been there.Review of the physician orders revealed Resident #27 did not have an order to self-administer medications or for medications to be left at bedside.Interview on 12/22/25 at 10:25 A.M. with Licensed Practical Nurse (LPN) # 361 revealed she administered Resident #27's medications, confirmed she left the medications on the bedside table and further confirmed Resident #27 does not have an order for self-administration or for medications to be left at bedside.Review of facility policy titled, Medication Storage in the Facility dated May 2020, revealed medications are stored safely, securely, and properly, following manufacturers' recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.

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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** Based on record review, self reported incident review, and interview the facility failed to ensure the incident log was complete and accurate for a resident fall and failed to ensure a resident's medical record was complete. This affected one resident (#55) of two residents reviewed for accidents. The facility census was 47.Findings include:Review of the medical record for Resident #55 revealed an admission date of 09/24/25. Diagnoses included infection following a procedure surgical site, cellulitis of left lower limb, muscle weakness, dysphagia, cognitive communication deficit, repeated falls, fracture of left femur, acute respiratory failure with hypoxia, anemia, and anxiety. Review of a Minimum Data Set (MDS) version 3.0, dated 10/13/25, revealed a Basic Interview for Mental Status (BIMS) of seven on a 0-15 scale. A BIMS score of seven would indicate severe problems with thinking and memory. It also indicated the resident needed assistance with all activities of daily living (ADLs).Review of a Care Plan, dated 10/21/25, revealed Resident #55 had anemia and was at risk for fatigue, weakness, and confusion. Interventions included observing the resident for the following signs and symptoms associated with anemia: pale skin, fatigue, shortness of breath, headaches, insomnia, dizziness, leg cramping, increased heartbeat and altered blood values such as low hemoglobin. Further review of the Care Plan revealed the resident was at risk for falls/injury related to confusion, history of falls, and incontinence of bowel and urine. Interventions included with device use, to observe for potential mental and physical side effects such as lethargy, mood changes, mobility changes, skin integrity changes, and toileting changes; and to report side effects to the physician or nurse practitioner (NP).Review of Self-Reported Incident (SRI) #267738 submitted to the Ohio Department of Health (ODH) on 11/19/25 revealed an investigation was initiated by the facility following an allegation of possible physical abuse. The SRI revealed Resident #55 was discharged to the hospital on [DATE] following a non-SRI related critical lab finding. Resident #55's daughter contacted the facility on 11/19/25 to report the resident had bruising on her right hip and possibly small bruises on her back. There was no alleged perpetrator. Staff were interviewed and it was revealed that over the weekend, 11/15-11/16/25, staff had attempted to utilize a mechanical lift known as a sit-to-stand to safely transfer the resident. Staff stated Resident #55 demonstrated a noticeable right-side lean during this time and had to be highly encouraged to keep her feet in place. Staff stated the resident had rubbed her right hip area against device on multiple occasions and leaned in the back support brace with most of her body weight. The night shift nurse and aide noticed a small quarter-sized reddened/pink area located on the right hip while providing care on the night of 11/17/25. On the morning of 11/18/25 preceding the resident's transfer to the hospital, the certified nursing assistant (CNA) notified the nurse on duty of the area as well, however, before she could be examined, the resident was sent to the hospital. At no time did the resident voice concerns of pain or issues with the area. It was reported by staff that the resident demonstrated a right-side lean multiple times while transferring, causing the resident's hip to come into contact with the assistive device. The resident also put her full weight into the supportive sling that was wrapped around her back, which is the most likely explanation for the alleged bruising. The facility unsubstantiated the allegation of abuse.Review of a nursing progress note, dated 11/16/25 at 12:31 P.M., (authored by Licensed Practical Nurse (LPN) #318) revealed she was alerted by CNA that Resident #55 appeared weak while utilizing the sit-to-stand device. Respirations were even and unlabored with respiratory rate of 18, pulse was 88, blood pressure was 124/75, oxygen saturation was 87% on room air. The resident was alert and oriented to self and surroundings and did mention to her spouse while visiting that she fell and was running around the facility all night, which she did not. She was easily reoriented and able to answer questions and express needs. She stated she just feels tired today. Review of a progress note for Resident #55, dated 11/17/25 at 12:55 P.M. revealed a nurse was called to Resident #55's bathroom. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon entering bathroom, resident was noted to be sitting on the toilet. Face noted to be pale but resident alert. Speech noted to be slurred at this time but appropriate responses. Staff assist resident off the toilet and to her wheelchair. Noted that resident had a large formed BM in the toilet. Noted that once in wheelchair, resident regained color to her face and was alert and oriented and stated that she felt better. Able to carry a conversation with this nurse. Noted that when this nurse left the room resident was eating a donut prior to going to her appointment. Husband at bedside. Call light and fluids within reach. The resident record failed to reveal communication with the resident's primary care provider regarding a change in her condition. This was confirmed by Nurse Practitioner (NP) #401 on 12/23/25 at 5:02 P.M.An Interview on 12/23/25 at 5:02 P.M. with NP #401 confirmed she did not recall being notified of incident on 11/17/25, but was notified later in the week when the resident had an episode of weakness/pallor and slurred speech at which time she ordered a hemoglobin level to be checked. Review of a progress note for Resident #55, dated 11/18/25 at 11:23 A.M., revealed a note from IDT (interdisciplinary team). This note was noted to actually be documented on 11/24/25 at 10:39 A.M. as a late entry. The note indicated on chart review it had been found the night shift LPN (Licensed Practical Nurse) noted new bruising to the right hip area on 11/17/25 , which had been identified as a clustered small area of newer looking discoloration to right side hip area through the night by both STNA (state tested nurse assistant) and LPN per completed pink man form, area is consistent per interview with staff with resident bumping off sit to stand on Sunday evening. Per LPN interview when resident during a weak episode slammed body down into sit to stand on right side and her back, at the time of incident there were no noted injuries per interview with staff resident was educated after incident and safely transferred into bed and assessed thoroughly with no major obvious and/or finding's. Review of the facility incident and accident log failed to reveal an incident regarding Resident #55 on 11/16/25. This was confirmed by the Director of Nursing (DON) on 12/29/25 at 9:51 A.M. On 12/29/25 at 9:51 A.M., an interview with the Director of Nursing (DON) confirmed the nursing progress notes failed to contain documentation of 11/16/25 transfer incident and incidents of ongoing weakness. The DON confirmed the incident and accident log did not reflect the incident on 11/16/25 regarding Resident #55.