

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2025
NAME OF PROVIDER OR SUPPLIER Lincoln Crawford Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1346 Lincoln Avenue Cincinnati, OH 45206	
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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility document and policy review, the facility failed to protect 3 (Resident #55, Resident #58, and Resident #53) of 3 residents ' right to be free from physical/mental abuse by another resident. On 05/26/2025, before the evening meal in the dining room, dietary staff observed Resident #95 attempt to hit their roommate, Resident #55. Dietary staff separated the residents and instructed the residents to go upstairs. Later that evening, staff transferred Resident #55 to the emergency department (ED) due to bleeding from the resident ' s head. While at the ED, Resident #55 stated that Resident #95 hit them multiple times with a cane. This resulted in Actual Harm when Resident #55 was hospitalized and diagnosed with a fractured right arm, received six sutures to a laceration to their head, and was diagnosed with acute blood loss anemia. The failure to protect Resident #55 from abuse resulted in injuries which left Resident #55 being dependent on staff for all activities of daily living (ADL) due to the resident ' s inability to use their upper extremities. In addition, on 06/18/2025 at 7:30 PM in the facility's courtyard, Resident #53 reported hearing Resident #58 talking about them and when Resident #53 approached Resident #58, Resident #58 called Resident #53's family member an expletive and pushed Resident #53 away. Resident #53 then hit Resident #58 in the face, and Resident #53 placed their hands around Resident #58's neck. Resident #31 separated Resident #53 and Resident #58. Findings included: A facility document titled, Abuse and Neglect Protocol, revised 06/13/2021, revealed, Our residents have the right to be free from abuse, neglect misappropriation of resident property, exploitation, corporal punishment, physical or chemical restraints imposed for purpose of discipline or convenience, and not required to treat the resident's medical symptoms, and involuntary seclusion. The policy revealed 1. Our facility does not condone resident abuse by anyone, including staff members, physicians, consultants, volunteers, staff or other agencies serving the resident, family members, legal guardians, sponsors, other residents, friends, or other individuals. 2. To help with recognition of incidents of abuse, the following definitions of abuse are provided. a. 'Abuse' is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. The policy revealed, 'Willful,' as used in this definition of abuse, means the individual must have acted deliberately. b. 'Verbal abuse' is defined as any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability. e. 'Mental abuse' is defined as, but not limited to, humiliation, harassment, threats of punishment, or withholding of treatment or services. 1. An admission Record indicated the facility originally admitted Resident #55 on 02/18/2014. According to the admission Record, the resident had a medical history that included diagnoses of hemiplegia (paralysis) and hemiparesis following a cerebral infarction affecting the nondominant left side and cerebrovascular disease. (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 0600 Level of Harm - Actual harm Residents Affected - Few	An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/09/2025, revealed Resident #55 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed Resident #55 had limitations in range of motion of the upper extremity on one side of the body. Resident #55's Care Plan Report included a focus area initiated 05/21/2020, that indicated the resident was at risk for developing complications secondary to an ADL self-care performance deficit. Interventions directed one staff member to provide setup/clean-up assistance with eating, personal hygiene and oral care (initiated 05/21/2020); supervision/touching assistance with toileting and transfers from sitting to standing positions, chair/bed-to-chair transfers, and toilet transfers (initiated 08/16/2020); and partial/moderate assistance for showers/bathing (initiated 05/21/2020). The Care Plan Report also included a focus area initiated 05/21/2020, that indicated Resident #55 was at risk for complications secondary to limited physical mobility related to a stroke and weakness. Interventions directed staff to have the resident use a wheelchair for locomotion (initiated 05/21/2020) and provide supervision and staff set up for mobility (initiated 10/14/2020). Resident #55's Medication Administration Record dated 05/2025 revealed Resident #55 received clopidogrel bisulfate (an antiplatelet medication) 75 mg (milligram) tablet one time a day related to other cerebrovascular disease and apixaban (an anticoagulant medication) 5 mg tablet twice a day for atrial fibrillation from 05/01/2025 through the morning dose on 05/26/2025. An admission Record indicated the facility admitted Resident #95 on 06/29/2023. According to the admission Record, the resident had a medical history that included diagnoses of peripheral vascular disease, depressive disorder, and mild cognitive impairment. A quarterly MDS, with an ARD of 03/04/2025, revealed Resident #95 had a BIMS score of 15, which indicated the resident had intact cognition. Resident #55's Progress Notes dated 05/26/2025 at 7:37 PM, revealed the resident's roommate (Resident #95) reported to the nurse's aide during report rounds that Resident #55 hit their head multiple times on their bedframe causing a massive head bleed. The notes revealed staff called 911 and sent Resident #55 to the emergency room (ER) for further evaluation. Resident #55's Trauma Surgery H&P [History and Physical] dated 05/26/2025 at 10:45 PM, revealed Resident #55 sustained a fall from standing height, and a trauma alert was received because the resident took anticoagulant medication. Per the H&P, the resident had a three-centimeter (cm) laceration to the forehead with a hematoma (a localized collection of blood) and an arterial bleed, and the resident had a right ulna fracture (the bone from the elbow to the little finger side of the wrist). Per the H&P, the ulna bone was minimally displaced, mildly angulated, and mildly comminuted (the bone was broken in two or more places and usually resulted from trauma). Per the H&P, Resident #55 admitted to the hospital to trauma services. The hospital Trauma/Critical Ill Assessment dated 05/26/2025 at 9:11 PM, indicated an ambulance brought Resident #55 in for an evaluation of injuries from fall. The assessment revealed at 2:00 AM, Resident #55 reported to a registered nurse (RN) that their roommate (Resident #98) assaulted them and they did not fall. The assessment revealed a social worker spoke with the resident to confirm what the resident reported to the RN. Per the assessment, Resident #55 wanted to speak to the police about what happened, and the social worker notified the police department. (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 08/08/2025 at 3:13 PM, CNA #19 stated Resident #95 told her that Resident #55 fell. CNA #19 stated she remembered seeing Resident #55 on 05/26/2025 in the hallway with their head bleeding and the resident would not say what happened. She stated Resident #95 kept saying Resident fell and hit their head on the footboard of the bed; however, per CNA #19, there was no blood in the area. During an interview on 08/08/2025 at 8:12 AM, the Director of Rehabilitation (DOR) stated that prior to hospitalization, Resident #55 was able to walk with a hemi-cane (a type of walker designed for use for individuals with one-sided weakness) during therapy. The DOR stated therapy evaluated Resident #55 the day they returned from the hospital and because the resident could not bear weight to their right arm and had residual effects in their left arm from a prior stroke, Resident #55 was left dependent on staff for all activities of daily living. The DOR stated Resident #55 could also no longer use their hemi-walker, which left Resident #55 completely dependent for all care. During an interview on 08/08/2025 at 11:07 AM, the DON stated if Resident #55 fell on the floor, she did not think the resident would have been able to get off the floor without staff assistance. The DON stated that when they interviewed Resident #95 on 05/26/2025, the resident stated that Resident #55 hit their head on the footboard when they fell. The DON stated that Resident #55 did not tell them what happened when the incident occurred but reported to the hospital that their roommate assaulted them. Per the DON, the facility investigated, and looked at the cane, walker, and bed frame and they did not find any blood. She stated that because Resident #55 had some dementia, they did not credit the resident as having accountability. During an interview on 08/08/2025 at 12:04 PM, the Administrator stated abuse was anything verbal, physical, emotional, or mental that caused intentional harm to another resident. The Administrator indicated he was aware there had been some interactions that occurred in the dining room, but he was not aware Resident #95 attempted to hit Resident #55 while in the dining room. He stated the example of Resident #95 attempting to hit Resident #55 would be considered an example of potential abuse, and if the episode was witnessed, the residents should be separated to ensure safety, then the staff member should notify the DON or the Administrator. According to the Administrator, he visited Resident #55 in the hospital, and the resident told him about being attacked by their roommate. The Administrator stated he placed Resident #95 on one-to-one supervisor the morning of 05/27/2025, when he was notified of the incident, and the resident remained on one-to-one supervision for caution until the danger passed. The Administrator indicated he did not think Resident #95 needed to remain on one-to-one supervision after Resident #55 returned to the facility on the following day, 05/28/2025, because he thought the events that occurred were more behavioral. Per the Administrator, the facility did not substantiate abuse. He stated he was unable to determine whether the case was behavioral, or abuse and he felt that the situation was reactive as opposed to abusive based on his investigation. 2. An admission Record revealed the facility admitted Resident #53 on 01/04/2023. According to the admission Record, the resident had a medical history that included a diagnosis of tobacco use. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/25/2025, revealed Resident #53 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #53's Care Plan Report revealed a focus area initiated 01/04/2023, that indicated the resident was a smoker. (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An admission Record revealed the facility admitted Resident #58 on 05/03/2025. According to the admission Record, the resident had a medical history that included diagnoses of depression, anxiety disorder, and post-traumatic stress disorder. An admission MDS, with an ARD of 05/09/2025, revealed Resident #58 had a BIMS score of 15, which indicated the resident had intact cognition. Resident #58's Care Plan Report included a focus area initiated 05/23/2025, that indicated the resident was a smoker The facility Self-Reported Incident Form, dated 06/18/2025, indicated an incident of physical abuse, a resident as a victim, and another resident as the alleged perpetrator. The facility Narrative Summary of Incident revealed on 06/18/2025 at 7:30 PM, Resident #53 came to a nurse and reported an altercation with Resident #58 in the courtyard, and the nurse confirmed that both residents were safe and separated. The summary indicated Resident #58 reported Resident #53 approached them unprovoked, hit them #58 in the face, and placed their hands around their neck. The summary indicated Resident #53 reported hearing Resident #58 talking about Resident #53, and when Resident #53 approached, Resident #58 called Resident #53's family member an expletive and pushed Resident #53 away. The summary indicated Resident #53 directed physical force at Resident #58, and another resident separated the two residents in the courtyard. The summary indicated there were no other witnesses to the alleged event. The summary indicated the Director of Nursing (DON) and Administrator were notified of the incident. The summary indicated the police were called per both residents' requests. The summary indicated Resident #58 declined to go to the emergency room. The Conclusion indicated the facility unsubstantiated the allegation, the evidence was inclusive, and abuse, neglect, and misappropriation were not suspected. During an interview on 08/07/2025 at 8:50 AM, Resident #53 stated they remembered the incident with Resident #58 outside in the courtyard after smoking time. Resident #53 stated several residents were present. Resident #53 stated they were unsure if any staff were present, maybe a staff member who worked on the second floor was there, but the resident could not remember the staff member's name. Resident #53 stated that Resident #58 was talking about their family member and started to shake their head. Resident #53 stated Resident #31 intervened to separate them. Resident #53 stated there were no other times when they hit someone. Resident #53 stated they told the nurse about the fight. During an interview on 08/07/2025 at 1:20 PM, Resident #31 stated there had been some altercations during the smoke breaks, and they would get in between the residents involved because they did not like violence. Resident #31 stated the day Resident #53 and Resident #58 got into it, they had been out smoking, and they were arguing back and forth, Resident #58 called Resident #53's family member an expletive, and Resident #53 punched Resident #58, then Resident #58 punched Resident #53, and Resident #53 tried to choke Resident #58. Resident #31 stated they got in between the two residents to break it up. A quarterly MDS, with an ARD of 07/07/2025, revealed Resident #31 had a BIMS score of 15, which indicated the resident had intact cognition. During an interview on 08/07/2025 at 10:55 PM, Registered Nurse (RN) #12 stated in June 20205 or July 2025 an incident happened at shift change in the courtyard when Resident #53 and Resident #58 were arguing. RN #12 stated she did not witness any hands-on interaction between the two residents. RN #12 stated each resident claimed they were the victim and the other was the aggressor. RN #12 stated she separated the residents, interviewed each of the residents, and called the DON. RN #12 stated Resident #58 stated Resident #53 started it. RN #12 stated both residents were offered to change rooms, but they refused, and 1:1 (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	observation was provided for Resident #58. During an interview on 08/08/2025 at 11:39 AM, the DON stated she knew there had been a verbal altercation, could not remember exactly how it started, but knew Resident #58 said something about Resident #53's family member and then the residents started arguing and it escalated. The DON stated it happened in the courtyard, she did not remember if any staff were present, and there were other residents outside to include Resident #31. The DON stated Resident #31 tried to break it up. The DON stated her expectation was to make sure the residents felt safe. During an interview on 08/08/2025 at 12:35 PM, the Administrator stated he was notified almost instantly, at about 8:00 PM, of the incident.		

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F 0607 Level of Harm - Actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview, record review, and facility policy review, the facility failed to implement their policy for abuse prohibition for 1 (Resident #55) of 2 residents. Specifically, a dietary aide (DA) witnessed Resident #95 attempt to hit Resident #55 in the dining room on 05/26/2025. The staff member separated the residents and directed them to return to the unit where they resided; however, the incident was not reported to the Director of Nursing (DON), the nurse supervisor on duty, or Administrator as required per facility policy. Once Resident #55 returned to their room, the resident stated that Resident #95 struck them in their head with a cane. The failure resulted in a Actual Harm when Resident #55 sustained a laceration to the head with an arterial bleed and a right arm fracture which coupled with previous left arm paralysis, left Resident #55 unable to use their upper extremities and dependent on staff for all activities of daily living. Findings include: The facility document titled, Abuse and Neglect Protocol revised 06/13/2021, revealed, It is the responsibility of our employees, facility consultants, Attending Physician's, family members, visitors, etc., to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management. The policy revealed, 4. Employees, facility consultants and/or Attending Physicians must immediately report any suspected abuse or incidents of abuse to the Director of Nursing Services. In the absence of the Director of Nursing Services such reports may be made to the Nurse Supervisor on duty. 5. Any individual observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to the Administrator or Director of Nursing Services. The following information should be reported: a. The name(s) of the resident(s) to which the abuse or suspected abuse occurred; b. The date and time that the incident occurred; c. Where the incident took place; d. The name(s) of the person(s) allegedly committing the incident, if known; e. The name(s) of any witnesses to the incident; f. The type of abuse that was committed (i.e., verbal, physical, sexual, neglect, etc.); and g. Any other information that may be requested by management. Per the policy, 8. The Administrator or Director of Nursing Services must be immediately notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after hours, the Administrator and Director of Nursing Services must be called at home or must be paged and informed of the incident. 9. When an incident of resident abuse is suspected or confirmed, the incident must be immediately reported to the facility management regardless of the time lapse since the incident occurred. Reporting procedures should be followed as outlined in this policy. An admission Record indicated the facility originally admitted Resident #55 on 02/18/2014. According to the admission Record, the resident had a medical history that included diagnoses of hemiplegia (paralysis) and hemiparesis following a cerebral infarction affecting the nondominant left side and cerebrovascular disease. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/09/2025, revealed Resident #55 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed Resident #55 had limitations in range of motion of the upper extremity on one side of the body. Resident #55's Care Plan Report included a focus area initiated 05/21/2020, that indicated the resident was at risk for developing complications secondary to an ADL self-care performance deficit. Interventions directed one staff member to provide setup/clean-up assistance with eating, personal hygiene and oral care (initiated 05/21/2020); supervision/touching assistance with toileting and transfers from sitting to standing positions, chair/bed-to-chair transfers, and toilet transfers (initiated 08/16/2020); and partial/moderate assistance for showers/bathing (initiated 05/21/2020). The Care Plan Report also included a focus area initiated 05/21/2020, that indicated Resident #55 was at risk for complications secondary to limited physical mobility related to a stroke and weakness. Interventions directed staff to have the resident use a wheelchair for locomotion (initiated 05/21/2020) and provide supervision and staff set up for mobility (initiated 10/14/2020). An admission Record indicated the facility admitted Resident #95 on 06/29/2023. According to the (continued on next page)		

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F 0607 Level of Harm - Actual harm Residents Affected - Few	admission Record, the resident had a medical history that included diagnoses of peripheral vascular disease, depressive disorder, and mild cognitive impairment. A quarterly MDS, with an ARD of 03/04/2025, revealed Resident #95 had a BIMS score of 15, which indicated the resident had intact cognition. During an interview on 08/05/2025 at 1:34 PM, Resident #55 stated that a couple months prior, while downstairs in the cafeteria area speaking with Resident #62, and waiting for their meal to be delivered, Resident #95 approached them and bumped their wheelchair several times, despite having ample room to get around. Resident #55 stated they initially attempted to move closer toward the table to give Resident #95 room to get around the wheelchair, but Resident #95 continued to bump their wheelchair and attempted to hit them. Resident #55 stated that at that time, they began to roll their wheelchair backward and tried to use their foot to tap Resident #95's knee in an attempt to get the resident to stop, back off, and go around. Per Resident #55, a female staff member came from the kitchen when Resident #62 yelled for help. Resident #55 stated the staff member told them they had to move and go upstairs. Resident #55 stated Resident #95 left the dining area first and they returned to the unit later. Resident #55 stated they recalled getting off the elevator on the 300 Hall unit where they resided and started down the hallway towards their room. Resident #55 stated they passed Resident #95, who was seated in their wheelchair in the hallway outside their room. Resident #55 stated they cautiously passed Resident #95 but did not speak and went into their room. Resident #55 stated that once in the room they turned around, and Resident #95 was coming toward them with a metal cane and struck them a couple of times to the right side of their head. Per Resident #55, they tried to keep Resident #95 from hitting them with the cane again. Resident #55 stated their head was bleeding. Per Resident #55, Resident #95 told them that they had better tell the nurse that they fell or things would be worse. Resident #55 stated they became very apprehensive and more guarded and went to the nurse's station and told staff that they needed help. Resident #55 stated they had not been out of their wheelchair and did not fall. Resident #55 stated that a nurse placed towels on their head, but the bleeding did not stop before going to the hospital. Resident #55 stated they were too afraid to say anything before they left the facility because they was afraid the situation might get worse. Resident #55 stated at the hospital, they had to get staples in their head and they learned that their right arm/wrist was broken and had to get a cast. Resident #55 stated that upon return to the facility, they asked for a different room, away from Resident #95. During an interview on 08/06/2025 at 8:47 AM, Resident #62 stated they were at a table in the dining room speaking with Resident #55 when Resident #95 approached them and hit Resident #55. Resident #62 stated they screamed for help because they were concerned that Resident #95 would harm Resident #55. During an interview on 08/06/2025 at 11:35 AM, Dietary Aide (DA) #21 stated she was working in the dietary department on the meal service tray line on 05/26/2025 when she heard a scream from Resident #62. Per DA #21, Resident #62 yelled for Resident #95 to stop. DA #21 stated that as she proceeded out of the swinging doors of the dietary department, she saw Resident #55 seated in their wheelchair and Resident #95 was in front of Resident #55, swinging at the resident. DA #21 stated she pulled Resident #55 backward and told the residents to go upstairs. She stated she then returned to the kitchen and began her cleaning duties. DA #21 stated that later that evening at approximately 8:00 PM, she was getting ready to leave the facility when she saw Resident #55 on a stretcher with a bloody head. During an interview on 08/06/2025 at 8:36 AM, DA #22 stated she recalled Resident #55 and Resident #95 were in the dining room and there was a lot of noise. She stated that she was working on the tray line with DA #21 and they heard a resident yelling for help. DA #22 stated she heard DA #21 leave the tray line and then heard DA #21 yell for the residents to stop. DA #22 stated that when she approached the door, she could hear Resident #95 cursing at DA #21 and heard DA #21 tell Resident #55 to move backwards, and Resident #55 immediately moved out of the way. Per DA #22, DA #21 stated that Resident #95 was getting ready to go after Resident #55 when she yelled. DA #22 stated that Resident #55 seemed to be glad that someone came so they could get away. DA #21 stated that it was the first time she had seen the residents escalate to that degree and it scared her. She stated (continued on next page)		

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

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F 0607 Level of Harm - Actual harm Residents Affected - Few	that following the interaction, both she and DA #21 returned to the kitchen and began breaking down the tray line and cleaning the kitchen for the night and stated neither of them reported the incident. During an interview on 08/08/2025 at 8:12 AM, the Director of Rehabilitation (DOR) stated that prior to hospitalization, Resident #55 was able to walk with a hemi-cane (a type of walker designed for use for individuals with one-sided weakness) during therapy. The DOR stated therapy evaluated Resident #55 the day they returned from the hospital and because the resident could not bear weight to their right arm and had residual effects in their left arm from a prior stroke, Resident #55 was left dependent on staff for all activities of daily living. The DOR stated Resident #55 could also no longer use their hemi-walker, which left Resident #55 completely dependent for all care. During an interview on 08/08/2025 at 11:07 AM, the DON stated staff were trained to notify a member of management immediately if there was confirmed or suspected case of abuse. The DON stated she expected the staff to separate the residents and report incidents to management. The DON stated they did not learn of the incident in the dining room on 05/26/2025, during their investigation of Resident #55's abuse allegation. During an interview on 08/08/2025 at 12:04 PM, the Administrator stated abuse was anything verbal, physical, emotional, or mental that caused intentional harm to the other person. The Administrator stated that he believed repeated bumping of the wheelchairs and Resident #95 cursing at Resident #55 to be situational and not abusive in nature; however, he stated that when Resident #95 attempted to hit Resident #55, that would be considered abusive. The Administrator stated that he was not aware that Resident #95 was swinging at Resident #55 in the dining room on 05/26/2025. He stated if staff witnessed the event, they were to separate the residents and ensure the residents were safe, then report it to the DON or the Administrator. He stated he expected the staff to have reported the situation immediately.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and facility policy review, the facility failed to ensure 1 (300 hall) of 2 shower rooms were maintained in a clean condition. Findings included: An undated facility policy titled, Bathrooms revealed 1. Bathrooms, including showers, whirlpools, century baths, commodes, etc., will be cleaned daily in accordance with our established procedures. An observation on 08/04/2025 at 1:54 PM revealed the 300 hall shower room had pieces of cotton from a wound dressing on the shower floor in stall #1, the floor throughout the entire shower room appeared with a thick brown grime substance on the tiles, a large shower chair with a broken seat which exposed a jagged and sharp appearance along the inner ring, a shower bench/riser with dirty areas and white substance in spots on the seat and rusty metal legs, and multiple open and unlabeled bottles of body wash, peri-wash, and deodorant. The shower nozzle from the shower head was hanging in the downward position to the floor and thick black hair covering all the drains in the three shower stalls. A toilet located in the common area with no curtain for privacy contained feces and thick brownish rings in the inside of the toilet bowl and a hand washing sink that contained a rust color rings in the basin of the sink with a large puddle of water in the floor between the toilet and the sink. An observation and interview with the Administrator present on 08/05/2025 at 4:13 AM revealed the 300 hall shower room remained in the same appearance as the above observation from the day prior. The Administrator acknowledged there should not have been a cotton dressing on the floor in the stalls, he stated the toilet should have been cleaned and feces should not remain in the toilet. He stated the broken chair should be taken out of use and not remain in the shower room. He also verified there should not be water standing in the floor and the sink should have been cleaned from the brown substance in the sink basin. He stated he would expect the shower room to be cleaned by the nursing department and sanitized at all times for bathing to be a good experience for each resident during their use. An observation and interview were conducted with the Housekeeping Director (HD) on 08/08/2025 at 10:56 AM. The HD observed and revealed the 300 hall shower room was to be cleaned by the housekeeper assigned to the 300 hall odd numbered rooms. She stated the shower room was to be cleaned daily by the assigned housekeeper. The HD acknowledged the floor was dirty and stated the floors should be mopped and the drains checked daily, although she stated housekeeping was not responsible for removing hair from the clogged drain and she was unsure who was responsible for that portion of drain checks. She stated the water standing in the floor was from the sink or toilet leaking which caused the puddle to reform each time it was mopped. During an interview on 08/08/2025 at 10:56 AM, the Director of Nursing (DON) indicated she would expect the shower rooms to be cleaned by the aides after each resident use by picking up the personal items used and tidying up the area, then housekeeping was to mop and sanitize the rest of the shower room at least one to two times per day. This deficiency represents non-compliance investigated under Complaint Number 1348402 (OH00167337) and 1348400 (OH00166666).		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, facility policy, and facility document review, the facility failed to consistently implement a program to ensure resident safety while smoking for 6 (Residents #6, #9, #4, #24, #31, and #49) of 29 residents who smoked. Specifically, the facility failed to ensure residents did not keep smoking materials in their possession and did not give smoking materials to other residents per the facility's smoking policy and smoking agreement. Findings included: A facility policy, Smoking Policy & Residents, revised 07/2017, revealed This facility shall establish and maintain safe resident smoking practices. The policy interpretation and implementation directed, 1. Prior to, and upon admission, residents shall be informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. 6. The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. 9. A resident's ability to smoke safely will be re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff. 13. Residents [sic] privileges are not permitted to keep cigarettes, e-cigarettes, pipes, tobacco, lighters, matches, and other smoking articles in their possession. Residents are not permitted to give smoking articles to other residents. 15. The facility maintains the right to confiscate smoking articles found in violation of our smoking policy. 1. An admission Record indicated the facility admitted Resident #6 on 10/17/2024. According to the admission Record, Resident #6 had diagnoses that included dementia, chronic obstructive pulmonary disease, tobacco use, bipolar disorder, and anxiety. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/25/2025, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #6 had not exhibited any behaviors during the assessment period. A Smoking Safety Evaluation completed on 08/05/2025 indicated Resident #6 was able to smoke unsupervised, followed the smoking guidelines per policy, and returned smoking materials for storage. The smoking evaluation indicated that the facility stored Resident #6's smoking materials. Resident #6's care plan included a focus area initiated 11/06/2024 for smoking. The care plan indicated Resident #6 would not smoke without supervision. Interventions included educating the resident on the facility smoking policy and protocol, and to monitor/document/report any instances of noncompliance. An observation on 08/04/2025 at 1:34 PM revealed a pack of cigarettes on Resident #6's bed. In an interview at that time, Resident #6 stated staff kept their lighter and the resident was not supposed to keep the cigarettes. Resident #6 stated they were going to turn their cigarettes in to staff. In an interview on 08/06/2025 at 10:53 AM, Resident #6 stated they knew they were supposed to turn their cigarettes into staff, but the resident was not feeling well so had kept them and turned them in later. 2. An admission Record indicated the facility admitted Resident #9 on 05/16/2019. According to the admission Record, Resident #9 had diagnoses that included flaccid hemiplegia affecting nondominant (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	side, psychotic disorder, nicotine dependence, and post-traumatic stress disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/18/2025, revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #9 had not exhibited any behaviors during the assessment period. A Smoking Safety Evaluation completed on 08/05/2025 indicated Resident #9 required supervision while smoking. The resident followed the smoking guidelines per policy and returned smoking materials for storage. The smoking evaluation indicated that the facility stored Resident #9's smoking materials. Resident #9's care plan included a focus area initiated 05/16/2019 for smoking. The care plan indicated that Resident #9 would not smoke without supervision. Interventions included educating the resident on the facility smoking policy and protocol, and to monitor/document/report any instances of noncompliance. An observation on 08/06/2025 at 4:01 PM revealed Resident #9 asking a certified nurse aide (CNA) to get their cigarettes from their room. The CNA notified Resident #9 that she had to keep the cigarettes and take them downstairs for the resident. The CNA followed Resident #9 down in the elevator. The resident became irate, and once they were in the dining room, Resident #9 grabbed the cigarettes out of the CNA's hand. In an interview at that time, Resident #9 stated the cigarettes belonged to another resident. Resident #9 then went outside to the smoking area with the cigarettes. In an interview on 08/05/2025 at 9:00 AM, the Smoke Guard (SG) stated her responsibilities included cleaning up the smoking area and staying outside with the smokers. The SG stated she would light residents' cigarettes and supervise residents while they were outside smoking. The SG stated she had a daily smoking list of which residents smoked. The SG stated the Activities Director (AD) or Dietary Manager (DM) updated the smoking list. The SG stated that she used the smoking list to keep track of who she had given cigarettes to. The SG stated if residents took cigarettes outside of the smoking area she reported it to the DM or AD. In an interview on 08/06/2025 at 9:03 AM, Activity Assistant (AA) #14 stated she sometimes supervised the smokers. AA #14 stated none of the residents were supposed to keep their cigarettes. AA #14 stated if a resident did not want to give her their cigarettes, she would report it to the DM or Assistant DM. In an interview on 08/06/2025 at 9:10 AM, the DM stated she did the scheduling to ensure someone was supervising the smokers. The DM also stated her responsibilities included training the smoke guard. The DM stated if a resident did not want to turn in their cigarettes, she reported it to the Administrator (ADM) and Director of Nursing (DON). The DM stated she maintained the daily smoking list based on any new admissions who needed to be added or anyone who was discharged and needed to be removed. In an interview on 08/07/2025 at 4:40 PM, the Administrator (ADM) stated that no formal training was provided for other staff members who covered the smoking area when the full-time smoke guard was not there. In an interview on 08/08/2025 at 9:32 AM, CNA #12 stated that it was her second day working at the (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility, but she knew that residents went out back to smoke and that residents were not allowed to keep their own cigarettes. In an interview on 08/08/2025 at 9:38 AM, Registered Nurse (RN) #10 stated residents smoked outside in the smoking area. RN #10 stated residents were not supposed to keep their cigarettes on them, but some would try to sneak them. RN #10 stated if she saw a resident with cigarettes, she would take them and return the cigarettes to the cart. In an interview on 08/08/2025 at 10:11 AM, the Assistant Director of Nursing (ADON) stated she completed the smoking assessments after interviewing the residents and watching them smoke. The ADON stated that sometimes she would watch the residents smoke or the SG would watch the residents smoke. The ADON stated the smoke guard could also report any concerns and make recommendations. The ADON stated the smoking assessments were completed upon admission and quarterly. The ADON stated that anyone in management could update the daily smoking list. The ADON stated the purpose of the list was so the smoke guard knew which residents smoked and which residents had cigarettes. The ADON stated that when completing the smoking assessment, she determined that the resident followed the policy based on if the resident had been caught buying their own cigarettes or keeping their cigarettes. The ADON stated if a resident was identified as being non-compliant, they would update the resident's care plan with their noncompliance. The ADON initially stated Resident #9 followed the smoking policy. The ADON then confirmed that she would not be surprised to hear that Resident #9 had cigarettes in their room and had become irate when the CNA would not give them the cigarettes and grabbed the cigarettes out of the CNA's hand. In an interview on 08/08/2025 at 11:33 AM, the Administrator (ADM) stated his expectation was that residents would turn in their cigarettes to the smoke guard to be locked in a cart. The ADM stated residents should not be sharing cigarettes with other residents. The ADM stated if staff observed a resident with smoking supplies, the staff should try to take the cigarettes and report it to management. The ADM stated all the current smokers should be on the daily smoking list. The ADM stated it was a challenge to manage the smoking program. The ADM stated residents frequently went out of the facility and bought cigarettes or tried to keep their own cigarettes. The ADM stated they had implemented the smoke guard position to help supervise the smoking. 3. An admission Record for Resident #24 revealed the resident was admitted on [DATE] with diagnoses that included local infection of the skin and subcutaneous tissue, methicillin susceptible staphylococcus aureus (MRSA) infection, morbid obesity due to excessive calories, and opioid use. An admission Minimum Data Set (MDS), with an Assessment Reference Date of 07/24/2025, revealed the resident had a Brief Interview for Mental Status score of 15, indicating no cognitive impairment. The resident had not exhibited any behaviors. The resident used a walker for ambulation with no impairments on the upper or lower extremities. The resident currently used tobacco. A Smoking Safety Evaluation, dated 07/20/2025, revealed the resident did smoke. The direct observation section indicated the resident returned smoking materials for storage. The summary of the evaluation indicated the resident required supervised smoking, did not require a smoking apron, the facility stored the smoking materials, and the resident was educated on the facility's smoking policies and procedures. The evaluation indicated the resident's plan of care remained appropriate. A Smoking Agreement, signed by Resident #24 on 07/24/2025, revealed To accommodate the needs of our residents, [the facility] allows residents to smoke while residing at [the facility]. Considering (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the dangers associated with smoking, it is imperative that [the facility's] smoking rules are adhered to at all times. The smoking rules included: 2. Cigarettes and lighting materials will be kept locked at the Nurses Station. 3. Cigarettes and lighting materials may not be kept in the resident's possession at any time. 7. Cigarettes may be ignited only by a staff member or designee. 11. Failure to adhere to safe smoking practices may result in a denial of smoking privileges at [the facility]. Family and residents will be kept informed of issues that arises. Further, I have read and understand the smoking rules of [the facility]. I agree to adhere to [these] rules at all times. I understand that these rules were implemented for my safety as well as the safety of the residents and staff at [the facility]. Smoking is allowed as a privilege. Failure to keep these rules may result in a denial [of] the privilege to smoke. In addition, if at any time my physician and/or Director of Nursing (DON) determine that smoking may cause significant harm to myself or other residents (examples of this are: smoking while receiving oxygen, inability to hold a cigarette in a stable manner, etc.) I will discontinue smoking activity at [the facility]. A Smoker List 08/01/2025, provided by the facility as their list of known smokers, revealed that Resident #24 was on the list. A Daily Smoking List used by the Smoke Guard to know which residents had been assessed for safe smoking for 08/05/2025 through 08/08/2025 revealed that Resident #24 was not on the list. The top of the page read, Under the 'start' column, enter the 'Ending' number of cigarettes from the previous day. At each break, record the number of cigarettes smoked. If any cigarettes were added to the resident's box, enter that number and the 'Added' column. At the end of the day subtract from the 'start' number, the number of cigarettes smoked, and add the number of cigarettes added, and put the new under the 'Ending' column. You must ensure that residents turn in any extra cigarettes and/or lighters before entering the building! During an observation and interview on 08/04/2025 at 2:12 PM, Resident #24 was in their room walking to the bathroom. The resident had a cigarette lighter hanging off the front of their shirt with a nametag clip. Resident #24 stated that the resident kept the lighter, but the resident's spouse kept their cigarettes, and they were not there at that time. The staff kept everyone else's smoking materials. Resident #24 then asked if they were not supposed to have it, and if it should be hanging out of their shirt. Then the resident fumbled with it to put it back inside the shirt. An observation on 08/07/2025 at 1:15 PM revealed that Resident #24 was outside smoking. 4. An admission Record revealed Resident #4 was admitted on [DATE] with diagnoses that included acute kidney failure, type 2 diabetes mellitus, vascular dementia, mood disorder, and insomnia. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/05/2025, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had no cognitive impairment. The resident had no impairments of either the upper or lower extremities and used a walker and a wheelchair for ambulation. The resident was a current tobacco user. Resident #4's Care Plan Report revealed the resident was a smoker, with interventions that included to educate the resident on the facility's smoking policies and protocol, and to monitor/document/report any instances of noncompliance. A Smoking Safety Evaluation, dated 08/01/2025, revealed Resident #4 was a current smoker. The resident did not have any limitations of the upper and lower extremities. A direct observation indicated the resident returned smoking materials for storage. The evaluation indicated the resident (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	required supervised smoking, did not require a smoking apron, and the facility stored the resident's smoking materials. A Smoking Agreement, signed by Resident #4 on 05/06/2023, revealed To accommodate the needs of our residents, [the facility] allows residents to smoke while residing at [the facility]. Considering the dangers associated with smoking, it is imperative that [the facility's] smoking rules are adhered to at all times. The smoking rules included: 2. Cigarettes and lighting materials will be kept locked at the Nurses Station. 3. Cigarettes and lighting materials may not be kept in the resident's possession at any time. 7. Cigarettes may be ignited only by a staff member or designee. 11. Failure to adhere to safe smoking practices may result in a denial of smoking privileges at [the facility]. Family and residents will be kept informed of issues that arises. Further, I have read and understand the smoking rules of [the facility]. I agree to adhere to [these] rules at all times. I understand that these rules were implemented for my safety as well as the safety of the residents and staff at [the facility]. Smoking is allowed as a privilege. Failure to keep these rules may result in a denial [of] the privilege to smoke. In addition, if at any time my physician and/or Director of Nursing (DON) determine that smoking may cause significant harm to myself or other residents (examples of this are: smoking while receiving oxygen, inability to hold a cigarette in a stable manner, etc.) I will discontinue smoking activity at [the facility]. 5. An admission Record revealed Resident #49 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, schizophrenia, bipolar disorder, major depressive disorder, post-traumatic disorder, and disease of the spinal cord. A Smoking Safety Evaluation, dated 03/08/2025, revealed Resident #49 was a current smoker. The resident did not have any limitations. The resident required supervision while smoking, did not require a smoking apron, and the facility stored the smoking materials. A quarterly MDS, with an ARD of 05/13/2025, revealed Resident #49 had a BIMS of 15, which indicated no cognitive impairment and no behaviors. The resident used a wheelchair for mobility. A Smoking Agreement, signed by Resident #49 on 02/13/2025, revealed that To accommodate the needs of our residents, [the facility] allows residents to smoke while residing at [the facility]. Considering the dangers associated with smoking, it is imperative that [the facility's] smoking rules are adhered to at all times. The smoking rules included: 2. Cigarettes and lighting materials will be kept locked at the Nurses Station. 3. Cigarettes and lighting materials may not be kept in the resident's possession at any time. 7. Cigarettes may be ignited only by a staff member or designee. 11. Failure to adhere to safe smoking practices may result in a denial of smoking privileges at [the facility]. Family and residents will be kept informed of issues that arises. Further, I have read and understand the smoking rules of [the facility]. I agree to adhere to [these] rules at all times. I understand that these rules were implemented for my safety as well as the safety of the residents and staff at [the facility]. Smoking is allowed as a privilege. Failure to keep these rules may result in a denial [of] the privilege to smoke. In addition, if at any time my physician and/or Director of Nursing (DON) determine that smoking may cause significant harm to myself or other residents (examples of this are: smoking while receiving oxygen, inability to hold a cigarette in a stable manner, etc.) I will discontinue smoking activity at [the facility]. An observation on 08/05/2025 at 9:22 AM revealed Resident #4 walking with a walker through the dining room towards the elevator. As Resident #4 passed by Resident #49 in the hallway by the elevator, Resident #4 had two cigarettes that the resident passed to Resident #49 in a secretive (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	manner. No staff were around or witnessed the exchange. 6. An admission Record revealed Resident #31 was admitted to the facility on [DATE] with diagnoses that included unspecified injury of the cervical spinal cord, quadriplegia, chronic pain syndrome, major depressive disorder, generalized anxiety, and muscle wasting and atrophy. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/07/2025, revealed Resident #31 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. Resident #31's Care Plan Report revealed a focus area, initiated on 06/07/2023, that indicated the resident was a smoker. The interventions included to educate the resident on the facility smoking policies and protocols and that the resident required a smoking apron when smoking and was non-compliant with using the apron. The care plan also included a focus area, initiated on 07/10/2023, that indicated the resident was at risk for developing complications secondary to being non-compliant with care, medications, and treatments as ordered or recommended. On 02/27/2025, the plan was revised to add that the resident was non-compliant with using a smoking apron. A Smoking Safety Evaluation, dated 07/16/2025, revealed Resident #31 did smoke. The resident had limitations of the upper and lower body with a weak grasp and dropped items. The resident returned smoking materials for storage, required supervision with smoking and a smoking apron, and the facility stored the resident's smoking materials. A Smoking Agreement, signed by Resident #31 on 05/26/2023, revealed that To accommodate the needs of our residents, [the facility] allows residents to smoke while residing at [the facility]. Considering the dangers associated with smoking, it is imperative that [the facility's] smoking rules are adhered to at all times. The smoking rules included: 2. Cigarettes and lighting materials will be kept locked at the Nurses Station. 3. Cigarettes and lighting materials may not be kept in the resident's possession at any time. 7. Cigarettes may be ignited only by a staff member or designee. 11. Failure to adhere to safe smoking practices may result in a denial of smoking privileges at [the facility]. Family and residents will be kept informed of issues that arises. Further, I have read and understand the smoking rules of [the facility]. I agree to adhere to [these] rules at all times. I understand that these rules were implemented for my safety as well as the safety of the residents and staff at [the facility]. Smoking is allowed as a privilege. Failure to keep these rules may result in a denial [of] the privilege to smoke. In addition, if at any time my physician and/or Director of Nursing (DON) determine that smoking may cause significant harm to myself or other residents (examples of this are: smoking while receiving oxygen, inability to hold a cigarette in a stable manner, etc.) I will discontinue smoking activity at [the facility]. An observation on 08/07/2025 at 2:01 PM revealed Resident #31 was in the hallway by the receptionist desk with two cigarettes in their lap. Observation and interview on 08/05/2025 at 9:00 AM revealed the Smoke Guard (SG) came in to work at 7:00 AM and stayed outside with the smokers. She indicated she lit the residents' cigarettes. The SG stated some could light their own, but they were not supposed to keep their lighters on them. The SG stated the residents were not supposed to keep cigarettes either, but some were sneaky. She stated she walked around and kept an eye on the residents to ensure they were not keeping their cigarettes. If the residents did keep them, she reported them to the Activity Director (AD) or the Dietary Manager (DM). She stated she had a daily smoking list and marked it down when she gave the residents cigarettes. She stated activities and dietary staff updated the list. During an interview on (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	08/07/2025 at 3:38 PM, Laundry Aide (LA) #27 stated she covered the evenings for the SG and would be there until 8:00 PM. LA #27 indicated she had received training on giving the residents their cigarettes. She stated they were supposed to keep the residents' cigarettes locked in the cart, but some would not give them up. If they did not give them up, she would report them to nursing. She stated she would not fight with the residents over their cigarettes. During an interview on 08/08/2025 at 9:14 AM, the SG stated she came in at 6:30 AM. An observation of the smoking cart at the time of the interview revealed there were five packs of cigarettes in the top drawer. She stated that residents were not supposed to take cigarettes out of the smoking area, but every once in a while they would get past her. She stated she tried to stop them, but was not going to fight them. She stated she would give the residents two free cigarettes and if they did not smoke the free cigarettes she provided, she took them back and put them back in the pack for someone else to smoke. During an interview on 08/08/2025 at 10:11 AM, the Assistant Director of Nursing (ADON) stated the facility policy was that the facility kept the residents' cigarettes. If they found out residents were buying their own cigarettes or keeping their cigarettes, they completed room sweeps and updated the care plan with their noncompliance. During an interview on 08/08/2025 at 11:39 AM, the Director of Nursing (DON) stated that on admission they completed smoking assessments, went over the smoking policy with the residents to make sure they understood, and had them sign the consent form. They kept the residents' cigarettes to keep them on the cart. At smoke time, residents were given their materials to smoke then the residents were to turn them back in once the smoke break was over. She stated residents should not have smoking materials on their person. The DON stated residents should not be sharing their cigarettes. During an interview on 08/08/2025 at 11:33 AM and a follow up at 12:35 PM, the Administrator stated his expectation for smoking was that residents would turn in their cigarettes at the end of the smoke break and that staff should keep them locked in the cart. Residents' cigarettes should not be shared with anyone else. If staff saw a resident with smoking paraphernalia, staff should attempt to take it and report to management. The Administrator stated it was a challenge to manage smoking. The Administrator stated residents would come and go and sometimes bring smoking materials in or try to keep them. The Administrator indicated it was hard to search them all the time, that residents were really good at hiding stuff, and that was why they put the smoke guard in place.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview, record review, and facility document and policy review, the facility failed to provide a Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN, Form CMS [Centers for Medicare & Medicaid Services] - 10055) for 1 (Resident #14) of 3 residents reviewed for Medicare Beneficiary Protection Notification when discharged from Medicare Part A Services with benefit days remaining. Findings included: A facility policy titled, Medicare Advance Beneficiary and Medicare Non-Coverage Notices, dated 03/28/2023, indicated, 2. The facility issues the Skilled Nursing Facility Advance Beneficiary Notice (CMS form 10055) for the following triggering events, and the policy continued, 3. Termination - In the situation in which the facility proposes to stop furnishing all extended care items or services to a beneficiary because it expects that Medicare will not continue to pay for the items or services that a physician has ordered and the beneficiary would like to continue receiving the care, the SNF ABN is issued to the beneficiary before such extended care items or services are terminated. An admission Record revealed the facility admitted Resident #14 on 08/12/2024. According to the admission Record, the resident had a medical history that included diagnoses of seizures, congestive heart failure, and chronic respiratory failure with hypoxia. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/04/2025, revealed Resident #14 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident was independent with eating, required supervision or touching-assistance with toileting, and required partial/moderate assistance with showers. Resident #14's Care Plan Report included a focus area, revised 02/14/2025, that indicated the resident was at the facility for short term rehabilitation and would have a safe discharge to the community after completing rehabilitation with skilled nursing care and therapy. Interventions directed staff: to set up home health for the resident to continue services upon discharge; for social services to coordinate with therapy to ensure all required durable medical equipment (DME) was ordered; to provide education regarding diagnosis and medications so the resident could verbalize understanding; and to ensure the resident would follow up with a primary care physician (PCP) after discharge in a timely manner. A Beneficiary Notice Scenarios for Surveyors form completed by the facility revealed Resident #14 had a Medicare Part A Skilled Services Episode start date of 02/01/2025, and the last covered day of Part A Service was 03/14/2025. The Beneficiary Notice Scenarios for Surveyors revealed the SNF ABN form was not provided to Resident #14, and an unsigned, handwritten explanation revealed, unable to find an ABN and would have to think it may not have been done. During an interview on 08/06/2025 at 10:51 AM, the former Social Service Director (SSD) stated she was responsible for providing beneficiary notices to residents when she worked at the facility from Labor Day in 2024 until she left in June 2025. The former SSD stated a resident should be provided and sign a SNF ABN and a Notice of Medicare Non-Coverage (NOMNC) when discharged from Medicare Part A services and when the resident continued to remain in the facility. The former SSD stated she was not sure why the ABN was not provided to Resident #14 and was not sure where it was. The former SSD stated Resident #14 should have signed both the SNF ABN and NOMNC forms. During an interview on 08/06/2025 at 11:08 AM, the Business Office Manager (BOM) stated she did not normally complete the beneficiary protection notices but had helped complete the notices. The BOM stated the Administrator and Administrator in Training (AIT) were currently completing the beneficiary protection notices, and the former SSD was responsible for ensuring Resident #14 received and signed the beneficiary notices. The BOM stated SNF ABN and NOMNC forms should be provided to residents who were discharged from Medicare Part A and remained in the facility. The BOM stated Resident #14 should have signed a NOMNC and an ABN when their coverage was ending and they remained at the facility. The BOM stated that in February 2025 and March 2025, the former SSD was responsible for completing both the NOMNC and ABN for Resident #14. During an interview on 08/06/2025 at 11:16 AM, the Director of Nursing (DON) stated the Administrator and BOM were currently responsible for (continued on next page)		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completing and providing residents with the NOMNC and ABN. The DON stated both the NOMNC and SNF ABN should be provided to a resident prior to discharge from Medicare Part A services and who remained in the facility. The DON stated she was not sure why Resident #14 did not receive an SNF ABN. The DON stated she expected safe resident discharges. During an interview on 08/06/2025 at 1:52 PM, the Administrator stated the interdisciplinary team (IDT), composed of the Administrator DON, Assistant DON, SSD, MDS nurse, therapy department, and the dietary department, met every week and discussed the residents who were in therapy and when they were close to their skilled services ending. The Administrator stated the IDT decided when it was time to issue an ABN and NOMNC. The Administrator stated the SSD was responsible for ensuring beneficiary protection notices were provided to residents, but they had not had an SSD since June 2025. The Administrator stated he provided the beneficiary notices to residents. The Administrator stated the former SSD was responsible for providing Resident #14 with the NOMNC and SNF ABN. The Administrator stated Resident #14 did not receive the SNF ABN form probably because the former SSD did not provide the ABN to the resident. The Administrator stated he expected Resident #14 to receive a NOMNC and SNF ABN prior to discharge from their skilled services while remaining in the facility.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, facility document review, and facility policy review, the facility failed to report an incident of abuse to the Administrator and to the state survey agency within two hours for 1 (Resident #55) of 2 residents reviewed for abuse. Resident #55 was struck on the head with a metal cane by Resident #95, which resulted in bleeding from a head injury requiring transfer to the hospital for evaluation. Findings included: The facility document titled, Abuse and Neglect Protocol, revised 06/13/2021, revealed, It is the responsibility of our employees, facility consultants, Attending Physicians, family members, visitors, etc., to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management. 4. Employees, facility consultants and/or Attending Physicians must immediately report any suspected abuse or incidents of abuse to the Director of Nursing Services. In the absence of the Director of Nursing Services such reports may be made to the Nurse Supervisor on duty. 6. Any staff member or person affiliated with the facility who has witnessed or who believes that a resident has been a victim of mistreatment, abuse, neglect, or any other criminal offense shall immediately report, or cause a report to be made of, the mistreatment or offense. Failure to report such an incident may result in legal/criminal action being filed against the individual(s) withholding such information. 8. The Administrator or Director of Nursing Services must be immediately notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after hours, the Administrator and Director of Nursing Services must be called at home or must be paged and informed of the incident. 12. If an incident of suspected abuse occurs, facility shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury to designated state agency. The facility's abuse policy did not indicate that alleged violations involving abuse are to be reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse, with or without serious bodily injury. The facility's policy indicated that for an incident of suspected abuse, if the events that caused the suspicion results in serious bodily injury, then it should be reported immediately but not later than 24 hours. An admission Record indicated the facility admitted Resident #55 to the facility on [DATE] with a recent readmission of 05/09/2020. According to the admission Record, the resident had a medical history with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting left nondominant side, other cerebrovascular disease, post-traumatic stress disorder (PTSD), adjustment disorder, and depression. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/09/2025, revealed Resident #55 had a Brief Interview for Mental Status (BIMS) score of 15. The MDS also indicated Resident #55 had no behaviors, utilized a wheelchair for mobility and required supervision or touch assistance for transfers, did not ambulate, and received an anticoagulant. An admission Record indicated the facility admitted Resident #95 to the facility on [DATE]. According to the admission Record, the resident had a medical history with diagnoses that included peripheral vascular disease, major depressive disorder, mild cognitive impairment, mood disorder due to known physiological condition with depressive features, and depression. A quarterly MDS, with an ARD of 03/04/2025, revealed Resident #95 had a BIMS score of 15. The MDS also indicated Resident #95 had no behaviors, utilized a wheelchair for mobility, could ambulate 10 feet in room, corridor, or similar space, could ambulate 50 feet with two turns with supervision or touching assistance, and required supervision or touching assistance for wheeling 50 feet with two turns and substantial or maximum assistance for wheeling 150 feet in corridor or similar space. A State Reportable Incident Report (SRI) dated 05/27/2025 indicated Resident #55 had made an allegation of physical abuse against another resident. The document (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed Resident #55 was found bleeding. At the time of the incident, Resident #55, who was generally verbally expressive, declined to offer an explanation related to the incident to staff present. Resident #55 was sent to the hospital and at that time, the resident reported there had been an assault by the roommate. Resident #55's roommate, Resident #95, reported that Resident #55 had fallen from the wheelchair. The SRI's summary of the incident revealed that on 05/26/2025 at 7:30 PM in room [ROOM NUMBER], Resident #55 reported bleeding to the nurse. Resident #55's roommate, Resident #95, reported that Resident #55 fell and was injured, and Resident #95 had helped Resident #55 back into the resident's chair. Interviews with staff revealed there were no audible screams, shouts, scuffling, or anything that would indicate an altercation. Resident #55 was sent out with the squad (emergency medical services) to the hospital. The resident reported to the hospital that the resident was assaulted by their roommate. A confirmation email dated 05/27/2025 at 12:20 PM revealed the state agency had received the initial state reportable incident for incident #260864. A confirmation email dated 05/30/2025 at 4:10 PM revealed the state agency had received the final facility reported incident for incident #260864. During an interview on 08/05/2025 at 1:34 PM, Resident #55 was asked about the incident on 05/26/2025. Resident #55 explained that a couple months ago, they had been downstairs in the cafeteria area speaking with a female resident, whom which Resident #55 identified to be Resident #62, while they both waited for their supper to be delivered. Resident #55 indicated that while the two residents were talking, Resident #95 approached them and began to bump Resident #55's wheelchair, despite ample room being available to get around without collision. Resident #55 stated they initially attempted to move closer towards the table to give Resident #95 room to get around the wheelchair, but Resident #95 refused, continued to bump Resident #55's wheelchair, and began swinging their upper extremity at Resident #55. Resident #55 stated that at that time, they began to roll their wheelchair backward as Resident #95 continued to swing at them, and Resident #62 became frightened and yelled for help. Resident #55 stated that at about that time, the resident used their leg to try to nudge Resident #95's knee to get them to back off them, and Dietary Aide (DA) #21 a female staff member approached from the kitchen. DA #21 informed both residents that they needed to return to their units upstairs. Resident #55 indicated Resident #95 left the dining area before Resident #55 did that evening and later when Resident #55 returned to the unit, Resident #55 indicated they recalled getting off the elevator on the 300 Hall unit, where they resided as roommates, and started down the hallway towards the room. Resident #55 indicated they passed Resident #95, who was seated in their wheelchair in the hallway at the time. Resident #55 cautiously passed Resident #95 to proceed into their shared room, not speaking to Resident #95 at the time. Resident #55 indicated that once in the room they turned around and Resident #95 had entered and began swinging their metal cane, making contact with Resident #55's head a couple times. On the next swing of the cane, Resident #55 blocked the cane from making contact with their head by using their right upper extremity, which was struck by the metal cane. Resident #55 indicated the resident realized at that time they were bleeding from the head and Resident #95 told Resident #55 to tell the staff nurse that the resident had sustained a fall or things would get worse. Resident #55 left the room to seek assistance for their bleeding head. When the surveyor clarified whether Resident #55 had fallen, Resident #55 informed the surveyor they had never been out of their wheelchair nor hit their head during the events. Resident #55 stated they did not tell staff about the assault immediately out of fear of the situation becoming worse in the future. During an interview on 08/06/2025 at 8:47 AM about the incident on 05/26/2025, Resident #62 stated they were seated at a table in the dining room speaking with Resident #55 when Resident #95 approached them and hit Resident #55, causing fear. Resident #62 said they summoned for help. During an interview on 08/06/2025 at 11:35 AM, DA #21 revealed she was working in the dietary department on the meal service tray line on 05/26/2025 when she heard a scream from Resident #62, which she recalled was initially for Resident #95 to STOP. DA #21 stated that as she proceeded out of the swinging doors of the dietary department, Resident #55 was seated in their wheelchair, and DA #21 saw Resident #95 swing at Resident #55. DA (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#21 stated that when she saw Resident #95 swinging their hand to hit Resident #55, she attempted to pull Resident #55's wheelchair backwards. She stated she then returned to the kitchen and began her cleaning duties she had to complete before she could leave for her shift that evening. DA #21 stated later that evening, at approximately 8:00 PM, she was getting ready to leave the building for her shift when she saw Resident #55 on a stretcher with their head bloody and busted up pretty badly. DA #21 indicated Resident #95 was a much larger resident than Resident #55, and she felt Resident #55 would have been defenseless against Resident #95. DA #21 indicated she had not been interviewed or asked about the events since she witnessed the incident, and she did not report the incident to anyone at the time the event occurred. During an interview on 08/06/2025 at 8:36 AM, DA #22 revealed she was working in the dietary department on the meal service tray line on 05/26/2025 when she heard a lot of noise. She heard a resident yelling for help and saw DA #21 leave the tray line then heard DA #21 holler for the residents to stop. DA #22 stated when she approached the door, she could hear Resident #95 cursing at DA #21 and heard DA #21 tell Resident #55 to move backwards, and Resident #55 moved backwards. She stated that following the interaction, both she and DA #21 returned to the kitchen and began breaking down the tray line and cleaning the kitchen for the night and stated neither of them reported the event at the time because they were busy completing their nightly duties. During an interview on 08/06/2025 at 7:17 PM, LPN #16 revealed she was an agency employee and was on duty covering a shift on the night of 05/26/2025 beginning at 7:00 PM. LPN #16 indicated that shortly after shift change, she was at the nurses' station when an unidentified nurse aide notified her that Resident #55 was in the hallway bleeding from their head. She stated she was not the assigned nurse to either Resident #55 or Resident #95; however, she was assigned to the 300 Hall unit that night, and with her knowledge that Resident #55 was on a blood thinner, both she and LPN #15 gathered some dressing supplies and headed towards Resident #55, whom they located with a pretty significant amount of bleeding present when they arrived. LPN #16 stated Resident #55 was unable to verbalize what had occurred at the time, but she knew she needed to get the resident urgent treatment, so they applied pressure to the head and contacted emergency medical services (EMS) to transport as quickly as possible. LPN #16 stated that following Resident #55's departure to the hospital, both she and LPN #15 went down to the resident's room where Resident #55 and Resident #95 resided to ask Resident #95 what had occurred. LPN #16 indicated Resident #95 informed them that Resident #55 had fallen and hit their head on the footboard of the bed. LPN #16 indicated both she and LPN #15 looked at the footboard and the bed and did not see any blood on the bed. They found the information provided by Resident #95 less than believable because she did not think Resident #55 would be able to get up from the floor without staff assistance in the event of a fall. LPN #16 recalled seeing blood stains on the floor in the room far enough away from the resident's bed that it did not appear the resident hit the end of the bed. Blood was in the hallway and all over Resident #55's clothing that night. LPN #16 stated that at the time of the event, Resident #55 was bleeding too significantly from the head and she was unable to assess the puncture wound on the head prior to discharge. She stated she had not been made aware of any interaction that had occurred prior to the event that may have caused the escalation that night. LPN #16 stated she learned of the allegation of assault when LPN #15 called the hospital to obtain report and was notified at that time, but they did not notify anyone until it was passed along to the oncoming nurse at shift-to-shift report in the morning. In an interview on 08/08/2025 at 12:04 PM, the Administrator stated he learned of the event the following morning and felt the event had been reported timely to the state agency.		

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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. Based on interview, record review, document review, and facility policy review, the facility failed to have evidence that an allegation of abuse was thoroughly investigated for 1 (Resident #55) of 3 sampled residents reviewed for abuse. Specifically, on 05/26/2025, Resident #55 was transferred to the emergency department (ED) due to bleeding from their head. Prior to leaving the facility, Resident #55 did not report how the injury occurred; however, the resident's roommate, Resident #95 reported that the resident sustained the injuries from a fall. After arrival at the ED, where Resident #55 was diagnosed with a fractured right arm, a laceration to the head with an arterial bleed, and acute blood loss anemia, the resident told hospital staff that the injuries were a result of Resident #95 hitting them multiple times with a cane. The facility investigation revealed no documented evidence that the facility interviewed all staff who had knowledge of the incident and no documented evidence that they interviewed a resident who witnessed an altercation between the residents. The facility investigation also revealed that even though Resident #55 consistently reported that their injuries resulted from Resident #95 hitting them with a cane and there was no evidence that Resident #55 fell, the facility determined that Resident #55's story was inconsistent, and abuse was not suspected and unsubstantiated. The facility also failed to thoroughly investigate an incident of resident-to-resident abuse for 2 residents (Resident #53 and Resident #58) of 3 sampled residents reviewed for abuse. The facility further failed to provide protection to other residents in the facility. Specifically, Resident #31, a witness to the incident, was not interviewed during the investigation, and the facility provided one-to-one observation for the victim but not the alleged perpetrator. Findings included: A facility document titled, Abuse and Neglect Protocol, revised 06/13/2021, revealed, All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management. The policy revealed, 13. The individual conducting the investigation will, as [sic] a minimum: e. Review the completed documentation forms; f. Review the resident's medical record to determine events leading up to the incident; g. Interview the person(s) reporting the incident; h. Interview any witnesses to the incident; i. Interview the resident (as medically appropriate); j. Interview the resident's Attending Physician as needed to determine the resident's current level of cognitive function and medical condition; k. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; l. Interview the resident's roommate, family members, and visitors; m. Interview other residents to whom the accused employee provides care or services; and n. Review all events leading up to the alleged incident. o. Preserve all audio and video recordings of incident, if available/applicable. The policy also revealed, 15. Witness reports will be obtained in writing. Witnesses will be required to sign and date such reports. Either the witness will write his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member and have him/her sign and date it. 1. An admission Record indicated the facility originally admitted Resident #55 on 02/18/2014. According to the admission Record, the resident had a medical history that included diagnoses of hemiplegia (paralysis) and hemiparesis following a cerebral infarction affecting the nondominant left side and cerebrovascular disease. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/09/2025, revealed Resident #55 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed Resident #55 had limitations in range of motion of the upper extremity on one side of the body. Resident #55's Care Plan Report included a focus area initiated 05/21/2020, that indicated the resident was at risk for developing complications secondary to an ADL self-care performance deficit. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions directed one staff member to provide setup/clean-up assistance with eating, personal hygiene and oral care (initiated 05/21/2020); supervision/touching assistance with toileting and transfers from sitting to standing positions, chair/bed-to-chair transfers, and toilet transfers (initiated 08/16/2020); and partial/moderate assistance for showers/bathing (initiated 05/21/2020). The Care Plan Report also included a focus area initiated 05/21/2020, that indicated Resident #55 was at risk for complications secondary to limited physical mobility related to a stroke and weakness. Interventions directed staff to have the resident use a wheelchair for locomotion (initiated 05/21/2020) and provide supervision and staff set up for mobility (initiated 10/14/2020). An admission Record indicated the facility admitted Resident #95 on 06/29/2023. According to the admission Record, the resident had a medical history that included diagnoses of peripheral vascular disease, depressive disorder, and mild cognitive impairment. A quarterly MDS, with an ARD of 03/04/2025, revealed Resident #95 had a BIMS score of 15, which indicated the resident had intact cognition. The Self-Reported Incident Form dated 05/27/2025, revealed on 05/26/2025 at 7:30 PM, Resident #55 was found bleeding. At the time of the incident, Resident #55, who was generally verbally expressive, declined to offer an explanation to the staff related to the incident. The report revealed the facility sent Resident #55 to the hospital and at that time, the resident reported their roommate (Resident #95) assaulted them. According to the report, Resident #95, the roommate, reported that Resident #55 fell from their wheelchair and they helped Resident #55 back into their chair. Resident #55's Trauma Surgery H&P [History and Physical] dated 05/26/2025 at 10:45 PM, revealed Resident #55 sustained a fall from standing height, and a trauma alert was received because the resident took anticoagulant medication. Per the H&P, the resident had a three-centimeter (cm) laceration to the forehead with a hematoma (a localized collection of blood) and an arterial bleed, and the resident had a right ulna fracture (the bone from the elbow to the little finger side of the wrist). Per the H&P, the ulna bone was minimally displaced, mildly angulated, and mildly comminuted (the bone was broken in two or more places and usually resulted from trauma). Per the H&P, Resident #55 admitted to the hospital to trauma services. The hospital ED Notes Addendum dated 05/27/2025 at 1:15 AM, revealed Resident #55 informed an RN that they did not fall but was actually assaulted by their roommate. Per the note, Resident #55 stated their roommate went to hit them with a metal walker, and they attempted to block, which caused the radial fracture and head laceration. Resident #55's hospital nursing note dated 05/27/2025 at 4:43 AM, revealed when staff asked Resident #55 what happened, the resident stated their roommate hit [them] with a cane. Resident #55's Inpatient Surgery Discharge Summary dated 05/28/2025 at 11:52 AM, revealed Resident #55 presented after a reported fall from standing height at the facility. Resident #55 then told team members that they was assaulted by their roommate and did not fall. According to the discharge summary, trauma staff repaired the resident's head laceration with six sutures/stiches, and the resident had a follow up appointment at the trauma clinic to remove the sutures. Per the discharge summary, the resident had acute blood loss anemia and education was provided for post-traumatic stress disorder. The discharge summary also revealed that plastic surgery placed a splint on the resident's right arm, and the resident should not bear weight, avoid heavy lifting in the right extremity, and attend a follow up appointment. The discharge summary indicated the resident (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should take acetaminophen and Robaxin (a muscle relaxant) for pain control. Resident #95's One on one document revealed the facility began supervising the resident on 05/27/2025 at 10:00 AM and documented that staff observed the resident every fifteen minutes for 45 hours. During an interview on 08/05/2025 at 1:34 PM, Resident #55 stated that a couple months prior, while downstairs in the cafeteria area speaking with Resident #62, and waiting for their meal to be delivered, Resident #95 approached them and bumped their wheelchair several times, despite having ample room to get around. Resident #55 stated they initially attempted to move closer toward the table to give Resident #95 room to get around the wheelchair, but Resident #95 continued to bump their wheelchair and attempted to hit them. Resident #55 stated that at that time, they began to roll their wheelchair backward and tried to use their foot to tap Resident #95's knee in an attempt to get the resident to stop, back off, and go around. Per Resident #55, a female staff member came from the kitchen when Resident #62 yelled for help. Resident #55 stated the staff member told them they had to move and go upstairs. Resident #55 stated Resident #95 left the dining area first and they returned to the unit later. Resident #55 stated they recalled getting off the elevator on the 300 Hall unit where they resided and started down the hallway towards their room. Resident #55 stated they passed Resident #95, who was seated in their wheelchair in the hallway outside their room. Resident #55 stated they cautiously passed Resident #95 but did not speak and went into their room. Resident #55 stated that once in the room they turned around, and Resident #95 was coming toward them with a metal cane and struck them a couple of times to the right side of their head. Per Resident #55, they tried to keep Resident #95 from hitting them with the cane again. Resident #55 stated their head was bleeding. Per Resident #55, Resident #95 told them that they had better tell the nurse that they fell or things would be worse. Resident #55 stated they became very apprehensive and more guarded and went to the nurse's station and told staff that they needed help. Resident #55 stated they had not been out of their wheelchair and did not fall. Resident #55 stated that a nurse placed towels on their head, but the bleeding did not stop before going to the hospital. Resident #55 stated they were too afraid to say anything before they left the facility because they were afraid the situation might get worse. Resident #55 stated at the hospital, they had to get staples in their head and they learned that their right arm/wrist was broken and had to get a cast. Resident #55 stated that upon return to the facility, they asked for a different room, away from Resident #95. During an interview on 08/06/2025 at 8:47 AM, Resident #62 stated they were at a table in the dining room speaking with Resident #55 when Resident #95 approached them and hit Resident #55. Resident #62 stated they screamed for help because they were concerned that Resident #95 would harm Resident #55. During an interview on 08/06/2025 at 11:35 AM, Dietary Aide (DA) #21 stated she was working in the dietary department on the meal service tray line on 05/26/2025 when she heard a scream from Resident #62. Per DA #21, Resident #62 yelled for Resident #95 to stop. DA #21 stated that as she proceeded out of the swinging doors of the dietary department, she saw Resident #55 seated in their wheelchair and Resident #95 was in front of Resident #55, swinging at the resident. DA #21 stated she pulled Resident #55 backward and told the residents to go upstairs. She stated she then returned to the kitchen and began her cleaning duties. DA #21 stated that later that evening at approximately 8:00 PM, she was getting ready to leave the facility when she saw Resident #55 on a stretcher with a bloody head. During an interview on 08/06/2025 at 8:36 AM, DA #22 stated she recalled Resident #55 and Resident (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#95 were in the dining room and there was a lot of noise. She stated that she was working on the tray line with DA #21 and they heard a resident yelling for help. DA #22 stated she heard DA #21 leave the tray line and then heard DA #21 yell for the residents to stop. DA #22 stated that when she approached the door, she could hear Resident #95 cursing at DA #21 and heard DA #21 tell Resident #55 to move backwards, and Resident #55 immediately moved out of the way. Per DA #22, DA #21 stated that Resident #95 was getting ready to go after Resident #55 when she yelled. DA #22 stated that Resident #55 seemed to be glad that someone came so they could get away. DA #21 stated that it was the first time she had seen the residents escalate to that degree and it scared her. She stated that following the interaction, both she and DA #21 returned to the kitchen and began breaking down the tray line and cleaning the kitchen for the night and stated neither of them reported the incident. During an interview on 08/06/2025 at 7:53 PM, CNA #28 stated she was on duty on the night shift on 05/26/2025, and shortly after arriving on duty at 7:00 PM, Resident #55 was in a wheelchair, and their head was bleeding. She stated she notified an unidentified nurse, retrieved towels, and applied them to the resident's head to attempt to clean blood from the resident's face. She stated she recalled quite a bit of blood being on the resident's head and clothing, and on the floor. CNA #28 stated she also recalled Resident #95 sitting outside their door, saying something inappropriate, but could not remember what the resident said. CNA #28 stated that when she asked Resident #95 what happened, the resident stated that Resident #55 fell; however, she did not believe that Resident #55 would have been able to independently get up if they fell. During an interview on 08/06/2025 at 7:17 PM, Licensed Practical Nurse (LPN) #16 stated she was on duty covering a shift on the night of 05/26/2025 beginning at 7:00 PM. LPN #16 indicated that shortly after shift change, she was at the nurses' station when an unidentified nurse aide notified her that Resident #55 was in the hallway bleeding from their head. She stated she was not the assigned nurse to either Resident #55 or Resident #95; however, she was assigned to the 300 unit that night. LPN #16 stated that with her knowledge that Resident #55 was on a blood thinner and she and LPN #15 gathered dressing supplies and headed towards Resident #55. Per LPN #16, Resident #55 was bleeding pretty significantly when she arrived to assess the resident. LPN #16 stated Resident #55 was unable to describe what occurred. LPN #16 stated they applied pressure to the resident's head and contacted emergency medical services (EMS) to transport as quickly as possible. LPN #16 stated that following Resident #55's departure to the hospital, both she and LPN #15 asked Resident #95 what occurred, and the resident stated that Resident #55 fell and hit their head on the footboard of the bed. LPN #16 stated she recalled seeing blood stains on the floor in the room far enough away from the resident's bed that it did not appear the resident hit the end of the bed. LPN #16 stated that both she and LPN #15 looked at the footboard and all over the bed but did not see any blood on the bed. LPN #16 stated she found it hard to believe and did not think Resident #55 would be able to get up from the floor and back to their wheelchair independently after a fall or with the injuries the resident sustained. According to LPN #16, no one reported an altercation occurred prior to the incident. Per LPN #16 she did not learn of the allegation of assault until LPN #15 called the hospital to obtain a report on Resident #55. During an interview on 08/08/2025 at 3:13 PM, CNA #19 stated Resident #95 told her that Resident #55 fell. CNA #19 stated she remembered seeing Resident #55 on 05/26/2025 in the hallway with their head bleeding and the resident would not say what happened. She stated Resident #95 kept saying Resident fell and hit their head on the footboard of the bed; however, per CNA #19, there was no blood in the area. During an interview on 08/08/2025 at 8:12 AM, the Director of Rehabilitation (DOR) stated that prior (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to hospitalization, Resident #55 was able to walk with a hemi-cane (a type of walker designed for use for individuals with one-sided weakness) during therapy. The DOR stated therapy evaluated Resident #55 the day they returned from the hospital and because the resident could not bear weight to their right arm and had residual effects in their left arm from a prior stroke, Resident #55 was left dependent on staff for all activities of daily living. The DOR stated Resident #55 could also no longer use their hemi-walker, which left Resident #55 completely dependent for all care. The facility investigation revealed no documented evidence that the facility interviewed Resident #62, DA #21, DA #22, CNA #19, or LPN #16 as part of their investigation. According to the report, the facility unsubstantiated abuse, and indicated Evidence is inconclusive and Abuse, neglect or misappropriation is not suspected. During an interview on 08/08/2025 at 11:07 AM, the DON stated if Resident #55 fell on the floor, she did not think the resident would have been able to get off the floor without staff assistance. The DON stated that when they interviewed Resident #95 on 05/26/2025, the resident stated that Resident #55 hit their head on the footboard when they fell. The DON stated that Resident #55 did not tell them what happened when the incident occurred but reported to the hospital that their roommate assaulted them. Per the DON, the facility investigated, and looked at the cane, walker, and bed frame and they did not find any blood. She stated that because Resident #55 had some dementia, they did not credit the resident as having accountability. During an interview on 08/08/2025 at 12:04 PM, the Administrator stated abuse was anything verbal, physical, emotional, or mental that caused intentional harm to another resident. The Administrator indicated he was aware there had been some interactions that occurred in the dining room, but he was not aware Resident #95 attempted to hit Resident #55 while in the dining room. He stated the example of Resident #95 attempting to hit Resident #55 would be considered an example of potential abuse, and if the episode was witnessed, the residents should be separated to ensure safety, then the staff member should notify the DON or the Administrator. According to the Administrator, he visited Resident #55 in the hospital, and the resident told him about being attacked by their roommate. The Administrator stated he placed Resident #95 on one-to-one supervisor the morning of 05/27/2025, when he was notified of the incident, and the resident remained on one-to-one supervision for caution until the danger passed. The Administrator indicated he did not think Resident #95 needed to remain on one-to-one supervision after Resident #55 returned to the facility on the following day, 05/28/2025, because he thought the events that occurred were more behavioral. Per the Administrator, the facility did not substantiate abuse. He stated he was unable to determine whether the case was behavioral, or abuse and he felt that the situation was reactive as opposed to abusive based on his investigation. 2. An undated facility document titled Resident to Resident Altercation Checklist revealed that: all residents involved should be interviewed; interviews and written statements should be obtained from all staff members present in the facility; and appropriate interventions should be put into place to prevent future incidents. The Resident to Resident Altercation Checklist did not indicate how they would ensure the safety of any other residents in the facility. An admission Record revealed the facility admitted Resident #53 on 01/04/2023. According to the admission Record, the resident had a medical history that included a diagnosis of tobacco use. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/25/2025, revealed Resident #53 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated the (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident had intact cognition. Resident #53's Care Plan Report revealed a focus area initiated 01/04/2023, that indicated the resident was a smoker. An admission Record revealed the facility admitted Resident #58 on 05/03/2025. According to the admission Record, the resident had a medical history that included diagnoses of depression, anxiety disorder, and post-traumatic stress disorder. An admission MDS, with an ARD of 05/09/2025, revealed Resident #58 had a BIMS score of 15, which indicated the resident had intact cognition. Resident #58's Care Plan Report included a focus area initiated 05/23/2025, that indicated the resident was a smoker The facility Self-Reported Incident Form, dated 06/18/2025, indicated an incident of physical abuse, a resident as a victim, and another resident as the alleged perpetrator. The facility Narrative Summary of Incident revealed on 06/18/2025 at 7:30 PM, Resident #53 came to a nurse and reported an altercation with Resident #58 in the courtyard, and the nurse confirmed that both residents were safe and separated. The summary indicated Resident #58 reported Resident #53 approached them unprovoked, hit them #58 in the face, and placed their hands around their neck. The summary indicated Resident #53 reported hearing Resident #58 talking about Resident #53, and when Resident #53 approached, Resident #58 called Resident #53's family member an expletive and pushed Resident #53 away. The summary indicated Resident #53 directed physical force at Resident #58, and another resident separated the two residents in the courtyard. The summary indicated there were no other witnesses to the alleged event. The summary indicated the Director of Nursing (DON) and Administrator were notified of the incident. The summary indicated the police were called per both residents' requests. The summary indicated Resident #58 declined to go to the emergency room. The Conclusion indicated the facility unsubstantiated the allegation, the evidence was inclusive, and abuse, neglect, and misappropriation were not suspected. An untitled, facility document, dated beginning 06/19/2025 at 7:00 AM, with Resident #58's name handwritten across the top indicated 15 minute intervals checks for the resident's activity for 24 hours. The facility did not provide a log of resident activity checks for Resident #53. During an interview on 08/07/2025 at 1:20 PM, Resident #31 stated there had been some altercations during the smoke breaks, and they would get in between the residents involved because they did not like violence. Resident #31 stated the day Resident #53 and Resident #58 got into it, they had been out smoking, and they were arguing back and forth, Resident #58 called Resident #53's family member an expletive, and Resident #53 punched Resident #58, then Resident #58 punched Resident #53, and Resident #53 tried to choke Resident #58. Resident #31 stated they got in between the two residents to break it up. A quarterly MDS, with an ARD of 07/07/2025, revealed Resident #31 had a BIMS score of 15, which indicated the resident had intact cognition. During an interview on 08/07/2025 at 10:55 PM, Registered Nurse (RN) #12 stated in June 20205 or July 2025 an incident happened at shift change in the courtyard when Resident #53 and Resident #58 were arguing. RN #12 stated she did not witness any hands-on interaction between the two residents. RN #12 stated each resident claimed they were the victim and the other was the aggressor. RN #12 stated she separated the residents, interviewed each of the residents, and called the DON. RN #12 (continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2025
NAME OF PROVIDER OR SUPPLIER Lincoln Crawford Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1346 Lincoln Avenue Cincinnati, OH 45206	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated Resident #58 stated Resident #53 started it. RN #12 stated both residents were offered to change rooms, but they refused, and 1:1 observation was provided for Resident #58. The facility investigation documents included interviews with Resident #53 and Resident #58 but did not include an interview with Resident #31. During an interview on 08/08/2025 at 11:39 AM, the DON stated she knew there had been a verbal altercation, could not remember exactly how it started, but knew Resident #58 said something about Resident #53's family member and then the residents started arguing and it escalated. The DON stated it happened in the courtyard, she did not remember if any staff were present, and there were other residents outside to include Resident #31. The DON stated Resident #31 tried to break it up. The DON stated her expectation was to make sure the residents felt safe. During an interview on 08/07/2025 at 11:40, the Administrator stated their policy directed them to provide 1:1 observation for the aggressor after a resident to resident altercation, but this was a special case and Resident #58 could be aggressive toward other residents. The Administrator stated they should have provided 1:1 observation for the aggressor. The Administrator stated the facility did not provide 1:1 observation for both residents as he directed. During an interview on 08/08/2025 at 12:35 PM, the Administrator stated they should include interviews with all the witnesses. During an interview on 08/08/2025 at 3:08 PM, the Administrator stated he expected staff to interview anyone who was at the facility at that time and he did not realize they had not interviewed everyone in the facility.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, record review, and facility policy review, the facility failed to keep fingernails trimmed and clean for a resident (Resident #33) who was dependent on staff for activities of daily living (ADLs). Findings included: A facility policy titled, Care of Fingernails/Toenails, revised 10/2010 indicated, The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. The policy indicated, Nail care includes daily cleaning and regular trimming. The policy further indicated Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. An admission Record revealed the facility admitted Resident #33 on 05/05/2021. The admission Record indicated that Resident #33 had diagnoses that included type 2 diabetes mellitus, dementia, atherosclerotic heart disease, and chronic kidney disease. A quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 04/30/2025, revealed Resident #33 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact. The MDS indicated Resident #33 had not rejected care during the evaluation period. The MDS further indicated that Resident #33 required setup assistance with personal hygiene and partial to moderate assistance with bathing. Resident #33's Care Plan Report included a focus area revised 11/11/2021 that indicated the resident was at risk for complications related to an activities of daily living (ADL) performance deficit and was at increased risk for decline in function. Interventions included checking nail length and trimming and cleaning nails on bath day and as needed. An observation on 08/04/2025 at 1:57 PM revealed Resident #33 had long fingernails. Several of the resident's fingernails appeared 3/4 - 1 inches long. In an interview at that time, Resident #33 stated that they were waiting on staff to trim their nails, and that they did not usually keep them that long. An observation on 08/06/2025 at 10:21 AM revealed Resident #33 in the activity room on the 3rd floor. Resident #33's fingernails continued to be dirty, long, and jagged. In an interview at that time, the resident stated the resident needed to get staff to trim their nails. Resident #33 stated staff trimmed their nails whenever they want to. In an interview on 08/06/2025 at 10:23 AM, Certified Nurse Aide (CNA) #8 stated this was her first day working at the facility, and they did not tell her anything about trimming fingernails. CNA #8 looked at Resident #33's nails and stated that they needed trimmed and cleaned. CNA #8 offered to trim and clean the resident's nails that day, and Resident #33 agreed. In an interview on 08/06/2025 at 10:26 AM, Registered Nurse Unit Manager (RN UM) #9 stated CNAs were supposed to trim fingernails on shower days and as needed. RN UM #9 looked at Resident #33's nails. Resident #33 stated the middle nail had broken off. RN UM #9 asked Resident #33 if they wanted their fingernails trimmed. Resident #33 stated they would like their fingernails trimmed. Resident #33's shower sheets for the previous two weeks indicated the resident had refused showers four out of five days. The resident's shower sheets indicated Resident #33 had received a shower and nail trimming on 07/22/2025. In an interview on 08/07/2025 at 3:11 PM, CNA #1 stated the CNAs trimmed residents' fingernails unless the resident was diabetic, and then the nurse trimmed them. CNA #1 stated the nurse would tell her who was diabetic. CNA #1 stated Resident #33 would let her file their fingernails but would not let her cut them. In an interview on 08/08/2025 at 9:38 AM, RN #10 stated residents' fingernails were trimmed on their shower days or upon request. RN #10 stated if a resident was diabetic, the nurse would trim their nails. RN #10 stated she was not sure if the CNAs or the nurses trimmed Resident #33's nails. In an interview on 08/08/2025 at 9:40 AM, RN UM #9 asked RN #10 if Resident #33 was diabetic. RN #10 stated Resident #33 was not diabetic. RN UM #9 stated the CNAs would trim Resident #33's fingernails. RN #10 stated Resident #33 refused care, and their care plan reflected that the resident frequently refused care. RN #10 stated she was not sure when the care plan was updated to reflect noncompliance or refusal of care.		