STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366178	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Widows Home of Dayton	50 South Findlay Street Dayton, OH 45403

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interviews, and policy review, the facility failed to notify the physician or non-physician provider when a resident had an acute change in condition. This affected one (Resident #52) of three residents reviewed for a change in condition. The facility census was 65.Findings include:Review of the medical record for Resident #52 revealed an admission date of 09/25/25. Diagnoses included cerebral infarction (stroke), chronic obstructive pulmonary disease (COPD), and acute respiratory failure with hypoxia. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #52 had intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 15. Review of nurse's progress notes dated 01/31/26 from 11:00 A.M. to 10:55 P.M., revealed no documented evidence the physician or the non-physician provider was contacted when Resident #52 experienced an acute change in condition at approximately 1:00 P.M.Review of the nurse's progress note dated 01/31/26 at 10:56 P.M., authored by Registered Nurse (RN) #30, revealed Resident #52 had complaints of shocking feeling in his chest area. Upon assessment, he had a pacemaker, heart rate was obtained at 64 beats per minute (bpm) and then rechecked at 69 bpm. The on-call provider was contacted but did not answer. The nurse was awaiting a return call.Review of the nurse's progress note dated 02/01/26 at 12:55 A.M., authored by Licensed Practical Nurse (LPN) #23, revealed Resident #52 complained of an implantable cardioverter defibrillator (ICD) shock and stated it had been shocking him for the last four hours. Vital signs were obtained with a blood pressure (BP) of 94/59 millimeters of mercury (mmHg), 92 heart rate, 22 respirations, and oxygen saturation of 96 percent (%). Resident #52 requested to go to the emergency room because the shocks were scaring him. The on-call provider was contacted and agreed to send Resident #52 to the hospital for evaluation. The family and the Director of Nursing (DON) were notified. Review of the EMS report dated 02/01/26, revealed squad arrived on scene at 12:52 A.M. for a resident complaining of a shocking pain in his chest. Vital signs were taken at 1:02 A.M. with a BP of 118/72 mmHg, 156 heart rate, 18 respirations. At 1:13 A.M., the vital signs were BP 111/58 mmHg, 225 heart rate, 18 respirations. Assessment revealed Resident #52 had reported his ICD had shocked him 12 - 15 times in the last three hours. Resident #52 was in atrial fibrillation (A-fib) with rapid ventricular response (RVR). Resident #52 was transported to the hospital at 1:18 A.M.Review of the hospital paperwork dated 02/01/26, revealed Resident #52 presented to the emergency room complaining of experiencing repeated ICD firings. Resident #52 was a sixty-nine-year-old man with a history of coronary artery disease (CAD) caused by ischemic cardiomyopathy with an ejection fraction of 20-25 percent (%) status post three vein coronary artery bypass graft (CABG) and ICD placement. In the emergency room, Resident #52 required cardiology consultation and initiation of amiodarone (antiarrhythmic medication used to treat and prevent life-threatening, recurring, or persistent heart rhythm disorders, including ventricular arrhythmias [ventricular fibrillation/tachycardia] and rapid atrial fibrillation). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #52 was admitted to the ICU care unit for close monitoring in anticipation of electrophysiology (EP) intervention. Interview on 02/19/26 at 2:24 P.M., Resident #52 stated he was being shocked and requested to go to the hospital. Resident #52 stated the staff would not send him out at first but explained he was in a lot of discomfort when he was getting shocked.Interview on 02/23/26 at 1:27 P.M., LPN #22 stated she worked on 01/31/26 from 7:00 A.M. to 8:00 P.M. LPN #22 stated Resident #52 was screaming out and reported to her that a man was shocking him in his room, or the bed was shocking him. LPN #22 stated she thought he had a urinary tract infection (UTI) because he was not making any sense. LPN #22 stated she unplugged the bed and ensured the bed was working properly working. LPN #22 stated she did not know Resident #52 had an ICD. LPN #22 stated she obtained Resident #52's vital signs but did not document anything in the resident's medical records. LPN #22 stated she put a written entry in the provider's binder to follow up with Resident #52 but never called the provider about the acute change in conditions. Interview on 02/23/26 at 1:47 P.M., the DON stated the staff should be documenting in the medical records and notifying the provider when a resident experienced an acute change in condition. The DON stated she was not made aware of any complaints related to the resident being shocked until he was being sent out to the hospital on [DATE] at 1:00 A.M. The DON verified the provider was not notified when Resident #52 had an acute change in condition on 01/31/26.Review of the facility policy titled, Change in Condition, dated 11/06/25 revealed the facility was to ensure timely and appropriate response to changes in resident's conditions and to facilitate effective communication with physicians. The nursing staff must be vigilant in monitoring residents for any changes in condition including alterations in vital signs, mobility, cognition, mood, or behavior. When a nurse was notified of a change, the nurse would perform a comprehensive assessment to evaluate the severity and identify potential causes. The nurse would document all findings in the resident's medical record. The nurse must notify the attending physician or on-call physician immediately if the change in condition is significant.This deficiency represents noncompliance investigated under Complaint Number 2735210.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of hospital records, review of an emergency medical services (EMS) report, staff interviews, and policy review, the facility failed to provide timely, adequate and necessary care, monitoring and treatment for Resident #52 following an acute change in condition. Actual Harm occurred on 01/31/26 at approximately 1:00 P.M. when Resident #52 started receiving shocks from his implanted cardioverter defibrillator (ICD) (a battery-powered device placed under the skin to monitor, detect, and treat life-threatening heart arrhythmias). Resident #52 sustained numerous shocks from his ICD throughout the day with no intervention by staff. Resident #52 was sent to the hospital on [DATE] around 1:00 A.M. and required emergency medications to be stabilized and was admitted to the Intensive Care Unit (ICU) for monitoring and treatment. This affected one (Resident #52) of three residents reviewed for a change in condition. The facility census was 65.Findings include: Review of the medical record for Resident #52 revealed an admission date of 09/25/25. Diagnoses included cerebral infarction (stroke), chronic obstructive pulmonary disease (COPD), and acute respiratory failure with hypoxia. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #52 was alert and oriented. Review of the nurse's progress note dated 01/31/26 at 10:56 P.M., authored by Registered Nurse (RN) #30, revealed Resident #52 had complaints of a shocking feeling in his chest area. Upon assessment, he had a pacemaker, heart rate was obtained at 64 beats per minute (bpm) and then rechecked at 69 bpm. The on-call provider was contacted with no answer and nurse was awaiting a return call.Review of the nurse's progress note dated 01/31/26 at 11:03 P.M., authored by RN #30, revealed Resident #52 did not feel a shock in his chest and heart rate was 99 bpm.Review of the nurse's progress note dated 02/01/26 at 12:55 A.M., authored by Licensed Practical Nurse (LPN) #23, revealed Resident #52 complained of an implantable cardioverter defibrillator (ICD) shock and stated it had been shocking him for the last four hours. Vital signs were obtained with a blood pressure (BP) of 94/59 millimeters of mercury (mmHg), 92 heart rate, 22 respirations, and oxygen saturation of 96 percent. Resident #52 requested to go to the emergency room because the shocks were scaring him. The on-call provider was contacted and agreed to send Resident #52 to the hospital for evaluation. Resident #52's responsible party and the Director of Nursing (DON) were notified. Review of the EMS report dated 02/01/26, revealed the squad arrived on scene at 12:52 A.M. for a resident complaining of a shocking pain in his chest. Vital signs were taken at 1:02 A.M. with a BP of 118/72 mmHg, 156 heart rate, 18 respirations. At 1:13 A.M., the vital signs were BP 111/58 mmHg, 225 heart rate, 18 respirations. Assessment revealed Resident #52 had reported his ICD had shocked him 12 to 15 times in the last three hours. Resident #52 was in atrial fibrillation with rapid ventricular response. Resident #52 was transported to the hospital at 1:18 A.M.Review of the hospital paperwork dated 02/01/26, revealed Resident #52 presented to the emergency room complaining of experiencing repeated ICD firings. Resident #52 had a history of coronary artery disease caused by ischemic cardiomyopathy with an ejection fraction of 20-25 percent status post three vein coronary artery bypass graft and ICD placement. In the emergency room, Resident #52 required cardiology consultation and initiation of amiodarone (antiarrhythmic medication used to treat and prevent life-threatening, recurring, or persistent heart rhythm disorders, including ventricular arrhythmias and rapid atrial fibrillation). Resident #52 was admitted to the ICU care unit for close monitoring in anticipation of electrophysiology intervention. Review of the physician progress note dated 02/05/26 at 12:00 A.M., authored by Medical Director #100, revealed Resident #52 presented to the emergency room after his internal defibrillator went off 12-15 times in three hours. Resident #52 was in ventricular tachycardia with subsequent defibrillation on (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	his internal defibrillator. Laboratory findings were significant for hypokalemia (abnormally low potassium levels in the blood) with potassium level of 3.1 milliequivalents per liter (mEq/L) (abnormal is below 3.5 mEq/L). The resident's potassium was replaced, Resident #52 was given a bolus of amiodarone, and cardiology was consulted. Resident #52 was shocked greater than 35 times per the ICD report. Resident #52 was started on an esmolol drip (intravenous medication used primarily for rapid, short-term control of heart rate and blood pressure) lidocaine drip (intravenously antiarrhythmic medication to treat irregular heart rhythms), and amiodarone drip. Resident #52's ICD was upgraded to a dual-chamber ICD with insertion of right atrium lead. Resident #52 received five days of prophylactic antibiotics and then returned to the facility. During an interview on 02/19/26 at 2:24 P.M., Resident #52 stated he was being shocked and requested to go to the hospital. Resident #52 stated the staff would not send him out at first but explained he was in a lot of discomfort when he was getting shocked, and it woke him up out of his sleep.During an interview on 02/23/26 at 1:14 P.M., LPN #23 stated she started her shift on 01/31/26 after 11:00 P.M. LPN #23 stated she received a report from RN #30 that Resident #52 had been screaming out in pain most of the day because he was being shocked. LPN #23 stated an hour into her shift, Resident #52 started screaming out in pain. LPN #23 assessed him and reached out to the on-call provider to send him out the hospital to be evaluated. EMS were called and responded to Resident #52, who was later transported to the hospital.During an interview on 02/23/26 at 1:27 P.M., LPN #22 stated she worked on 01/31/26 from 7:00 A.M. to 8:00 P.M. LPN #22 stated Resident #52 was screaming out and reported to her that a man was shocking him in his room, or the bed was shocking him. LPN #22 stated she thought he had a urinary tract infection (UTI) because he was not making any sense. LPN #22 stated she unplugged the bed and ensured the bed was working properly. LPN #22 stated she did not know Resident #52 had an ICD. LPN #22 stated she made an entry in the binder for the provider to follow up with Resident #52 the following day. LPN #22 stated she obtained Resident #52's vital signs but did not document anything in the resident's medical records and did not notify the physician. LPN #22 stated she made a note in the provider's binder so a provider could follow-up with the resident.During an interview on 02/23/26 at 1:47 P.M., the DON stated Resident #52 had behaviors and would scream out. The DON stated the staff should be documenting changes in residents' condition and behaviors in the medical record. She was not made aware of any shocking complaints by Resident #52 until he was sent out to the hospital on [DATE].During an interview on 02/23/26 at 2:04 P.M., RN #30 stated he came in to relieve LPN #22 (day shift nurse) around 8:00 or 9:00 P.M. RN #30 stated he got a report that Resident #52 had been screaming out all day related to being shocked. RN #30 stated Resident #52 was screaming out when he first got on shift, but when he completed his first medication rounds at 8:30 P.M., Resident #52 had his eyes closed in bed. Around 9:30 P.M., Resident #52 started screaming out and when he went in to assess the resident, he reported he was being shocked by his pacemaker. RN #30 stated he did not know Resident #52 had a pacemaker until the resident mentioned it. RN #30 stated he reviewed the resident's record and verified the resident had a pacemaker. RN #30 stated he listened to the resident's heart and noticed an irregular and elevated rhythm. RN #30 reached out to the on-call provider and did not get an answer. RN #30 stated he was relieved by LPN #23 on 01/31/26 at approximately 11:00 P.M. and mentioned in his report that Resident #52 had complained of being shocked by his pacemaker. RN #30 instructed LPN #23 to send Resident #52 out to the hospital if it occurred again. Review of the facility policy titled, Change in Condition, dated 11/06/25 revealed the facility was to ensure timely and appropriate response to changes in resident's conditions and to facilitate effective communication with physicians. Nursing staff must be vigilant in monitoring residents for any changes in condition including (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	alterations in vital signs, mobility, cognition, mood, or behavior. When the nurse was notified of change, the nurse would perform a comprehensive assessment to evaluate the severity and identify potential causes. The nurse would document all findings in the resident's medical record. The nurse must notify the attending physician or on-call physician immediately if the change in condition is significant.This deficiency represents noncompliance investigated under Complaint Number 2735210.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on personnel record review, staff interviews, and policy review, the facility failed to ensure employed Certified Nursing Assistants (CNA) were properly licensed with the State of Ohio. This had the ability to affect all 65 residents. The facility census was 65.Findings include: Review of the CNA #13's personnel file revealed a hire date of [DATE] for a housekeeper position. CNA #13's file contained a certificate of completion from an online Nurse Aide Competency Evaluation Program (NATCEP) with completion date of [DATE]. Review of CNA #13's timecard for February 2026 revealed 12-hour shifts were completed on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE], and [DATE].Interview on [DATE] at 10:04 A.M., the Director of Nursing (DON) verified CNA #13 was not licensed as a CNA. The DON stated CNA #13 finished her online CNA program in [DATE] but never took the state test for licensure. The DON stated CNA #13 was initially hired as a housekeeper and worked her way up to being a CNA. Interview on [DATE] at 11:17 A.M., CNA #13 verified she was not licensed as a CNA and was providing personal care to residents. CNA #13 reported she was late scheduling her state test for licensure, but it was cancelled during the government shutdown. CNA #13 stated the DON and Human Resources #70 were not aware that she did not complete her state test for licensure.Interview on [DATE] at 11:39 A.M., Human Resources #70 verified CNA #13 was not licensed as a CNA. HR #70 reported she missed following up with CNA #13 after her test was cancelled due to the shutdown.Review of the facility policy titled, Nursing Services and Sufficient Staff, dated [DATE], revealed the facility was to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.Review of the facility policy titled Required Training, Certification and Continuing Education of Nurse Aides revised on [DATE], revealed the facility would employ nurse aides that have successfully completed a state approved NATCEP and are awaiting certification results. Staff may be employed full-time and permanent but must provide documentation of certification within four months of their hire date. Facility would verify certification through the appropriate state's nurse aide registry. If an individual has not successfully completed a NATCEP at the time of employment, that individual may only function as a nurse aide if the individual has been verified to be currently enrolled in a State approved NATCEP and is a permanent employee in his/her first four months of employment in the facility.Review of the State of Ohio Nurse Aide Registry website at (https://odh.ohio.gov/know-our-programs/nurse-aide-registry/nurseaideregistry), revealed no current nor expired CNA license for CNA #13. This deficiency represents noncompliance investigated under Complaint Number 2784304 and 2723229.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interviews and policy review, the facility failed to ensure the residents' medical records were complete and accurately documented. This affected one (Resident #52) of three residents reviewed for documentation. The facility census was 65. Findings include: Review of the medical record for Resident #52 revealed an admission date of 09/25/25. Diagnoses included cerebral infarction (stroke), chronic obstructive pulmonary disease (COPD), and acute respiratory failure with hypoxia. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #52 had intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 15. Review of nurse's progress notes for Resident #52 dated 01/31/26 from 11:00 A.M. to 10:55 P.M., revealed no documentation regarding the resident's acute change in condition reported to Licensed Practical Nurse (LPN) #22 on 01/31/26 around 1:00 P.M. The first note in the medical record about Resident #52's acute change in condition was recorded on 01/31/26 at 10:56 P.M. Review of the EMS report dated 02/01/26, revealed squad arrived on scene at 12:52 A.M. for a resident complaining of a shocking pain in his chest. Resident #52 was in atrial fibrillation (A-fib) with rapid ventricular response (RVR). Resident #52 was transported to the hospital at 1:18 A.M.Review of the hospital paperwork dated 02/01/26, revealed Resident #52 presented to the emergency room complaining of experiencing repeated ICD firings. Resident #52 was a sixty-nine-year-old man with a history of coronary artery disease (CAD) caused by ischemic cardiomyopathy with an ejection fraction of 20-25 percent (%) status post three vein coronary artery bypass graft (CABG) and ICD placement. In the emergency room, Resident #52 required cardiology consultation and initiation of amiodarone (antiarrhythmic medication used to treat and prevent life-threatening, recurring, or persistent heart rhythm disorders, including ventricular arrhythmias [ventricular fibrillation/tachycardia] and rapid atrial fibrillation). Resident #52 was admitted to the ICU care unit for close monitoring in anticipation of electrophysiology (EP) intervention. Interview on 02/19/26 at 2:24 P.M., Resident #52 stated he was being shocked and requested to go to the hospital. Resident #52 stated the staff would not send him out at first but explained he was in a lot of discomfort when he was getting shocked, and it woke him up out of his sleep.Interview on 02/23/26 at 1:14 P.M., LPN #23 stated she started her shift after 11:00 P.M. on 01/31/26. LPN #23 stated she received a report from Registered N #30 that Resident #52 had been screaming out in pain most of the day because he was being shocked. LPN #23 stated an hour into her shift, Resident #52 started screaming out in pain. LPN #23 assessed him and reached out to the on-call provider to send him out the hospital to be evaluated. EMS were called and responded to Resident #52, who was later transported to the hospital.Interview on 02/23/26 at 1:27 P.M., LPN #22 stated she worked on 01/31/26 from 7:00 A.M. to 8:00 P.M. LPN #22 stated Resident #52 was screaming out and reported to her that a man was shocking him in his room, or the bed was shocking him. LPN #22 stated she thought he had a urinary tract infection (UTI) because he was not making any sense. LPN #22 stated she unplugged the bed and ensured the bed was working properly working. LPN #22 stated she did not know Resident #52 had an ICD. LPN #22 stated she obtained Resident #52's vital signs but did not document anything in the resident's medical records and did not notify the physician. LPN #22 stated she made a note in the provider's binder so a provider would follow-up with the resident during the next rounds. Interview on 02/23/26 at 1:47 P.M., the Director of Nursing (DON) stated the staff should be documenting in the residents' medical records when a resident experiences a change in condition. The DON verified Resident #52's medical record lacked any documentation from LPN #22 when the resident experienced the acute change in condition on 01/31/26. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/23/26 at 2:04 P.M., RN #30 stated he came in to relieve LPN #22 (day shift nurse) around 8:00 or 9:00 P.M. RN #30 stated he got a report that Resident #52 had been screaming out all day related to being shocked. RN #30 stated Resident #52 was screaming out when he first got on shift, but when he completed his first medication rounds at 8:30 P.M., Resident #52 had his eyes closed in bed. Around 9:30 P.M., Resident #52 started screaming out and when he went in to assess the resident, he reported he was being shocked by his pacemaker. RN #30 stated he did not know Resident #52 had a pacemaker until the resident mentioned it. RN #30 stated he reviewed the resident's record and verified the resident had a pacemaker. RN #30 stated he listened to the resident's heart and noticed an irregular and elevated rhythm. RN #30 reached out to the on-call provider and did not get an answer. RN #30 stated he was relieved by LPN #23 on 01/31/26 at approximately 11:00 P.M. and mentioned in his report that Resident #52 had complained of being shocked by his pacemaker. RN #30 instructed LPN #23 to send Resident #52 out to the hospital if it occurred again. Review of the facility policy titled, Change in Condition, dated 11/06/25 revealed the facility was to ensure timely and appropriate response to changes in resident's conditions and to facilitate effective communication with physicians. Nursing staff must be vigilant in monitoring residents for any changes in condition including alterations in vital signs, mobility, cognition, mood, or behavior. When the nurse was notified of change, the nurse would perform a comprehensive assessment to evaluate the severity and identify potential causes. The nurse would document all findings in the resident's medical record. The nurse must notify the attending physician or on-call physician immediately if the change in condition was significant.This deficiency represents noncompliance investigated under Complaint Number 2735210.