

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2026
NAME OF PROVIDER OR SUPPLIER Orrville Pointe		STREET ADDRESS, CITY, STATE, ZIP CODE 230 South Crown Hill Road Orrville, OH 44667	
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 - Minimal harm or potential for 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 policy review, the facility failed to protect Resident #31 from abuse and mistreatment on 06/11/26 at approximately 10:00 P.M. when Registered Nurse (RN) #107 forced a spoonful of applesauce and medications into Resident #31's mouth as she was unresponsive. This affected one Resident (#31) of three residents reviewed for abuse. The facility census was 45. Findings include: Review of the medical record for Resident #31 revealed an admission date of 11/30/24. Diagnoses included chronic obstructive pulmonary disease, type two diabetes mellitus, and chronic respiratory failure with hypoxia. Resident #31 passed away at the facility on 06/13/26. Review of the care plan dated 04/20/26 revealed Resident #31 was experiencing a significant decline in health status related to terminal illness. Interventions included to administer all medications as ordered and provide a supportive, private environment for resident and family. Review of the five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 had a severe cognitive impairment with a memory problem and required extensive assistance for all activities of daily living. Review of the physician's orders dated 06/11/26 revealed orders to administer Morphine (an opioid analgesic commonly used for end-of-life comfort measures) 20 milligrams (mg)/5 milliliters (ml), administer 5 mg (0.25 ml) every four hours routine for respiratory distress, and an additional order for Morphine 5 mg (0.25 ml) every two hours as needed for respiratory distress. Resident #31 had an additional order dated 03/06/26 for Lorazepam (also known as Ativan, an antianxiety medication commonly used for end-of-life restlessness) 0.5 mg one tablet by mouth every 4 hours as needed for agitation, restlessness, or anxiety. Review of the outside hospice nursing note dated 06/11/26 authored by Hospice Nurse #210 revealed a facility nurse attempted to administer medications to Resident #31 crushed in applesauce. Resident #31 was unresponsive at the time with deep shallow respirations. Her respiration rate was 27 breaths per minute. Hospice Nurse #210 asked the facility nurse not to continue to attempt to administer oral medications as Resident #31 was no longer responsive and may aspirate the applesauce as she was mouth breathing. The facility nurse proceeded to place the applesauce in Resident #31's mouth when Resident #31's daughter verbally requested the nurse leave the room. The facility nurse handed Hospice Nurse #210 the Morphine syringe and told her to give it then. Hospice Nurse #210 administered Resident #31's Morphine dose at 10:00 P.M. and attempted to remove the applesauce out of Resident #31's mouth as she was not swallowing it and continued mouth-breathing. Hospice Nurse #210 then left Resident #31's room and went to speak to the facility nurse who was placing her cart in the closet stating she was leaving the facility. A follow up note authored by Hospice Nurse #210 revealed the facility nurse locked her keys in her cart and left the building. Interview on 06/16/26 at 9:26 A.M. with Resident #31's daughter reported on 06/11/26 at approximately 10:00 P.M., RN #107 brought Resident #31's medication (Ativan) into the room crushed and mixed with applesauce. Hospice Nurse #210 informed RN #107 not to administer the Ativan to Resident #31 because she was unresponsive and no longer able to swallow. RN #107 proceeded to ignore Hospice Nurse #210 and forced her mother's lips open and shoved the medication/applesauce mixture into Resident #31's mouth. At that point, Resident #31's (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 - Minimal harm or potential for actual harm Residents Affected - Few	daughter reported she screamed for RN #107 to leave her mother's room. RN #107 began screaming at Hospice Nurse #210 and her and stated, well then who is going to administer this Morphine. Hospice Nurse #210 reached for the Morphine and RN #107 exited the room. The daughter and Hospice Nurse #210 then began removing the applesauce from Resident #31's mouth and Hospice Nurse #210 administered the Morphine to Resident #31. The daughter confirmed she believed this treatment by RN #107 to be abusive and they notified all administration of the incident. Resident #31's daughter reported she, Hospice Nurse #210, and Resident #31's son were all in the room, witnessed the behavior, and all felt it was abusive. Resident #31's daughter indicated Resident #31's son indicated he would contact the authorities for investigation into potential criminal charges if the facility did not investigate the incident with RN #107. Interview on 06/16/26 at 1:38 P.M. with the Administrator, Assistant Director of Nursing (ADON) #100, and Licensed Practical Nurse (LPN)/Clinical Manager (CM) #101 revealed the Administrator reported she got a call around 10:00 P.M. [on 06/11/26] that Resident #31's family was very upset about the care RN #107 was providing. She reported she then reached out to her clinical staff and ADON #100 reached out to RN #107 and informed her to go administer the Morphine to Resident #31. Around 12:00 A.M., LPN/CM #101 then received messages that RN #107 could not be located in the facility. LPN/CM #101 reported she got dressed and went to the facility and began reaching out to RN #107 who would only respond by text message. RN #107 informed LPN/CM #101 that she had counted the medications with the other nurse working the first floor and locked the medication carts along with the keys in the second-floor medication room. The Administrator, LPN/CM #101, and ADON #100 all confirmed Resident #31's family and Hospice Nurse #210 reported that RN #107 attempted to shove medication in applesauce into Resident #31's mouth when she was unresponsive. They reported they did not think of it as abuse and did not feel the need to report the incident to the state agency nor investigate the incident since RN #107 left the facility shortly after the incident occurred. Telephone interview on 06/16/26 at 3:43 P.M. with RN #107 confirmed she was very busy the night that Residents #31 was passing away. She reported that evening (06/11/26) she had been dealing with emergencies, so she administered nighttime medications to other residents late and they were upset so she did not want that to happen again. When Resident #31's family asked to have her 7:30 P.M. Morphine and Ativan administered she informed them they would have to wait. She then administered the medications to Resident #31 around 8:00 P.M. and at that time Resident #31 was able to swallow medications. When Resident #31 was due for her at 10:00 P.M. Ativan and Morphine, she prepared the Ativan in some applesauce and entered the room to administer it. Hospice Nurse #210 told her not to put the applesauce in Resident #31's mouth because she was no longer coherent and would not swallow it. RN #107 confirmed she told her she was still placing the Ativan into her mouth and used a spoon to place the Ativan in applesauce in her cheek. At that point, Resident #31's daughter screamed at RN #107 and informed her to leave the room. She left the Morphine syringe with Hospice Nurse #210 and exited the room, counted her narcotic drawers with the nurse from the first floor, clocked out of the facility, and left the facility around 11:30 P.M. She reported Resident #31 was able to swallow at 8:00 P.M. and her mouth was open when she entered the room but could not answer questions related to the resident's cognitive status or her level of alertness when she returned for the 10:00 P.M. dose. Review of the facility policy Abuse, Neglect, Exploitation, and Misappropriation Prevention Program, revised April 2021, revealed residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraints not required to treat the resident's symptoms. The facility must identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property, or injury of unknown source, the Administrator is responsible for determining what actions are needed for the protection of residents. All allegations are thoroughly investigated. The Administrator initiates (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigations. This deficiency represents non-compliance investigated under Complaint Number 3044559.		

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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, review of the Ohio Department of Health's Certification and Licensure System, and facility policy review, the facility failed to ensure an allegation of staff to resident abuse was reported to the State Agency as required. This affected one resident (#31) of three residents reviewed for abuse. The facility census was 45. Findings include: Review of the medical record for Resident #31 revealed an admission date of 11/30/24. Diagnoses included chronic obstructive pulmonary disease, type two diabetes mellitus, and chronic respiratory failure with hypoxia. Resident #31 passed away at the facility on 06/13/26. Review of the care plan dated 04/20/26 revealed Resident #31 was experiencing a significant decline in health status related to terminal illness. Interventions included to administer all medications as ordered and provide a supportive, private environment for resident and family. Review of the five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 had a severe cognitive impairment with a memory problem and required extensive assistance for all activities of daily living. Review of the physician's orders dated 06/11/26 revealed orders to administer Morphine (an opioid analgesic commonly used for end-of-life comfort measures) 20 milligrams (mg)/5 milliliters (ml), administer 5 mg (0.25 ml) every four hours routine for respiratory distress, and an additional order for Morphine 5 mg (0.25 ml) every two hours as needed for respiratory distress. Resident #31 had an additional order dated 03/06/26 for Lorazepam (also known as Ativan, an antianxiety medication commonly used for end-of-life restlessness) 0.5 mg one tablet by mouth every 4 hours as needed for agitation, restlessness, or anxiety. Review of the outside hospice nursing note dated 06/11/26 authored by Hospice Nurse #210 revealed a facility nurse attempted to administer medications to Resident #31 crushed in applesauce. Resident #31 was unresponsive at the time with deep shallow respirations. Her respiration rate was 27 breaths per minute. Hospice Nurse #210 asked the facility nurse not to continue to attempt to administer oral medications as Resident #31 was no longer responsive and may aspirate the applesauce as she was mouth breathing. The facility nurse proceeded to place the applesauce in Resident #31's mouth when Resident #31's daughter verbally requested the nurse leave the room. The facility nurse handed Hospice Nurse #210 the Morphine syringe and told her to give it then. Hospice Nurse #210 administered Resident #31's Morphine dose at 10:00 P.M. and attempted to remove the applesauce out of Resident #31's mouth as she was not swallowing it and continued mouth-breathing. Hospice Nurse #210 then left Resident #31's room and went to speak to the facility nurse who was placing her cart in the closet stating she was leaving the facility. Review of the Ohio Department of Health's (ODH) Certification and Licensure System (CALS) record of self-reported incidents (SRI) on 06/16/26 at 9:00 A.M. revealed no SRI had been reported involving Resident #31 on or around 06/11/26. Interview on 06/16/26 at 9:26 A.M. with Resident #31's daughter reported on 06/11/26 at approximately 10:00 P.M., RN #107 brought Resident #31's medication (Ativan) into the room crushed and mixed with applesauce. Hospice Nurse #210 informed RN #107 not to administer the Ativan to Resident #31 because she was unresponsive and no longer able to swallow. RN #107 proceeded to ignore Hospice Nurse #210 and forced her mother's lips open and shoved the medication/applesauce mixture into Resident #31's mouth. At that point, Resident #31's daughter reported she screamed for RN #107 to leave her mother's room. RN #107 began screaming at Hospice Nurse #210 and her and stated, well then who is going to administer this Morphine. Hospice Nurse #210 reached for the Morphine and RN #107 exited the room. The daughter and Hospice Nurse #210 then began removing the applesauce from Resident #31's mouth and Hospice Nurse #210 administered the Morphine to Resident #31. The daughter confirmed she believed this treatment by RN #107 to be abusive and they notified all administration of the incident. Resident #31's daughter reported she, Hospice Nurse #210, and Resident #31's son were all in the room, witnessed the behavior, and all felt it was abusive. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #31's daughter indicated Resident #31's son indicated he would contact the authorities for investigation into potential criminal charges if the facility did not investigate the incident with RN #107. Interview on 06/16/26 at 1:38 P.M. with the Administrator, Assistant Director of Nursing (ADON) #100, and Licensed Practical Nurse (LPN)/Clinical Manager (CM) #101 revealed the Administrator reported she got a call around 10:00 P.M. [on 06/11/26] that Resident #31's family was very upset about the care RN #107 was providing. She reported she then reached out to her clinical staff and ADON #100 reached out to RN #107 and informed her to go administer the Morphine to Resident #31. Around 12:00 A.M., LPN/CM #101 then received messages that RN #107 could not be located in the facility. LPN/CM #101 reported she got dressed and went to the facility and began reaching out to RN #107 who would only respond by text message. RN #107 informed LPN/CM #101 that she had counted the medications with the other nurse working the first floor and locked the medication carts along with the keys in the second-floor medication room. The Administrator, LPN/CM #101, and ADON #100 all confirmed Resident #31's family and Hospice Nurse #210 reported that RN #107 attempted to shove medication in applesauce into Resident #31's mouth when she was unresponsive. They reported they did not think of it as abuse and did not feel the need to report the incident to the state agency nor investigate the incident since RN #107 left the facility shortly after the incident occurred. Further review of the ODH CALS system revealed a SRI for possible staff to resident physical abuse was initiated on 06/16/26 at 2:05 P.M. The nursing staff involved was not named or listed as an alleged perpetrator. The SRI was completed on 06/19/26 at 1:17 P.M. and unsubstantiated the allegation of abuse as the evidence was inconclusive. The SRI summary noted the involved nurse is no longer employed by the facility and had not returned the facility's phone call for a first-hand statement. The root cause analysis referenced in the summary suggested the inappropriate administration was related to the nurse being overwhelmed with her tasks and duties but that did not negate her actions. The facility indicated the medication administration itself did not reflect abusive intent but the nurse later left the facility and her duties without ensuring adequate coverage for her tasks or obtaining approval to do so and the facility was pursuing action with her appropriate licensing board. Telephone interview on 06/16/26 at 3:43 P.M. with RN #107 confirmed she was very busy the night that Residents #31 was passing away. She reported that evening (06/11/26) she had been dealing with emergencies, so she administered nighttime medications to other residents late and they were upset so she did not want that to happen again. When Resident #31's family asked to have her 7:30 P.M. Morphine and Ativan administered she informed them they would have to wait. She then administered the medications to Resident #31 around 8:00 P.M. and at that time Resident #31 was able to swallow medications. When Resident #31 was due for her at 10:00 P.M. Ativan and Morphine, she prepared the Ativan in some applesauce and entered the room to administer it. Hospice Nurse #210 told her not to put the applesauce in Resident #31's mouth because she was no longer coherent and would not swallow it. RN #107 confirmed she told her she was still placing the Ativan into her mouth and used a spoon to place the Ativan in applesauce in her cheek. At that point, Resident #31's daughter screamed at RN #107 and informed her to leave the room. She left the Morphine syringe with Hospice Nurse #210 and exited the room, counted her narcotic drawers with the nurse from the first floor, clocked out of the facility, and left the facility around 11:30 P.M. She reported Resident #31 was able to swallow at 8:00 P.M. and her mouth was open when she entered the room but could not answer questions related to the resident's cognitive status or her level of alertness when she returned for the 10:00 P.M. dose. Review of the facility policy Abuse, Neglect, Exploitation, and Misappropriation Prevention Program, revised April 2021, revealed residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraints not required to treat the resident's symptoms. The facility must identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. Upon receiving any allegations of abuse, (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	neglect, exploitation, misappropriation of resident property, or injury of unknown source, the Administrator is responsible for determining what actions are needed for the protection of residents. All allegations are thoroughly investigated. The Administrator initiates investigations. This deficiency represents non-compliance investigated under Complaint Number 3044559.		

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of the Ohio Department of Health's Certification and Licensure System, and facility policy review, the facility failed to ensure an investigation into alleged of staff to resident abuse was timely and thoroughly investigated. This affected one Resident (#31) of three residents reviewed for abuse. The facility census was 45. Findings include: Review of the medical record for Resident #31 revealed an admission date of 11/30/24. Diagnoses included chronic obstructive pulmonary disease, type two diabetes mellitus, and chronic respiratory failure with hypoxia. Resident #31 passed away at the facility on 06/13/26. Review of the care plan dated 04/20/26 revealed Resident #31 was experiencing a significant decline in health status related to terminal illness. Interventions included to administer all medications as ordered and provide a supportive, private environment for resident and family. Review of the five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 had a severe cognitive impairment with a memory problem and required extensive assistance for all activities of daily living. Review of the physician's orders dated 06/11/26 revealed orders to administer Morphine (an opioid analgesic commonly used for end-of-life comfort measures) 20 milligrams (mg)/5 milliliters (ml), administer 5 mg (0.25 ml) every four hours routine for respiratory distress, and an additional order for Morphine 5 mg (0.25 ml) every two hours as needed for respiratory distress. Resident #31 had an additional order dated 03/06/26 for Lorazepam (also known as Ativan, an antianxiety medication commonly used for end-of-life restlessness) 0.5 mg one tablet by mouth every 4 hours as needed for agitation, restlessness, or anxiety. Review of the outside hospice nursing note dated 06/11/26 authored by Hospice Nurse #210 revealed a facility nurse attempted to administer medications to Resident #31 crushed in applesauce. Resident #31 was unresponsive at the time with deep shallow respirations. Her respiration rate was 27 breaths per minute. Hospice Nurse #210 asked the facility nurse not to continue to attempt to administer oral medications as Resident #31 was no longer responsive and may aspirate the applesauce as she was mouth breathing. The facility nurse proceeded to place the applesauce in Resident #31's mouth when Resident #31's daughter verbally requested the nurse leave the room. The facility nurse handed Hospice Nurse #210 the Morphine syringe and told her to give it then. Hospice Nurse #210 administered Resident #31's Morphine dose at 10:00 P.M. and attempted to remove the applesauce out of Resident #31's mouth as she was not swallowing it and continued mouth-breathing. Hospice Nurse #210 then left Resident #31's room and went to speak to the facility nurse who was placing her cart in the closet stating she was leaving the facility. Review of the Ohio Department of Health's (ODH) Certification and Licensure System (CALs) record of self-reported incidents (SRI) on 06/16/26 at 9:00 A.M. revealed no SRI had been reported involving Resident #31 on or around 06/11/26. Interview on 06/16/26 at 9:26 A.M. with Resident #31's daughter reported on 06/11/26 at approximately 10:00 P.M., RN #107 brought Resident #31's medication (Ativan) into the room crushed and mixed with applesauce. Hospice Nurse #210 informed RN #107 not to administer the Ativan to Resident #31 because she was unresponsive and no longer able to swallow. RN #107 proceeded to ignore Hospice Nurse #210 and forced her mother's lips open and shoved the medication/applesauce mixture into Resident #31's mouth. At that point, Resident #31's daughter reported she screamed for RN #107 to leave her mother's room. RN #107 began screaming at Hospice Nurse #210 and her and stated, well then who is going to administer this Morphine. Hospice Nurse #210 reached for the Morphine and RN #107 exited the room. The daughter and Hospice Nurse #210 then began removing the applesauce from Resident #31's mouth and Hospice Nurse #210 administered the Morphine to Resident #31. The daughter confirmed she believed this treatment by RN #107 to be abusive and they notified all administration of the incident. Resident #31's daughter reported she, Hospice Nurse #210, and Resident #31's son were all in the room, witnessed the behavior, and all felt it was abusive. Resident #31's daughter indicated Resident #31's son indicated he would contact the (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	authorities for investigation into potential criminal charges if the facility did not investigate the incident with RN #107. Interview on 06/16/26 at 1:38 P.M. with the Administrator, Assistant Director of Nursing (ADON) #100, and Licensed Practical Nurse (LPN)/Clinical Manager (CM) #101 revealed the Administrator reported she got a call around 10:00 P.M. [on 06/11/26] that Resident #31's family was very upset about the care RN #107 was providing. She reported she then reached out to her clinical staff and ADON #100 reached out to RN #107 and informed her to go administer the Morphine to Resident #31. Around 12:00 A.M., LPN/CM #101 then received messages that RN #107 could not be located in the facility. LPN/CM #101 reported she got dressed and went to the facility and began reaching out to RN #107 who would only respond by text message. RN #107 informed LPN/CM #101 that she had counted the medications with the other nurse working the first floor and locked the medication carts along with the keys in the second-floor medication room. The Administrator, LPN/CM #101, and ADON #100 all confirmed Resident #31's family and Hospice Nurse #210 reported that RN #107 attempted to shove medication in applesauce into Resident #31's mouth when she was unresponsive. They reported they did not think of it as abuse and did not feel the need to report the incident to the state agency nor investigate the incident since RN #107 left the facility shortly after the incident occurred. Further review of the ODH CALS system revealed a SRI for possible staff to resident physical abuse was initiated on 06/16/26 at 2:05 P.M. The nursing staff involved was not named or listed as an alleged perpetrator. The SRI was completed on 06/19/26 at 1:17 P.M. and unsubstantiated the allegation of abuse as the evidence was inconclusive. The SRI summary noted the involved nurse is no longer employed by the facility and had not returned the facility's phone call for a first-hand statement. The root cause analysis referenced in the summary suggested the inappropriate administration was related to the nurse being overwhelmed with her tasks and duties but that did not negate her actions. The facility indicated the medication administration itself did not reflect abusive intent but the nurse later left the facility and her duties without ensuring adequate coverage for her tasks or obtaining approval to do so and the facility was pursuing action with her appropriate licensing board. Telephone interview on 06/16/26 at 3:43 P.M. with RN #107 confirmed she was very busy the night that Residents #31 was passing away. She reported that evening (06/11/26) she had been dealing with emergencies, so she administered nighttime medications to other residents late and they were upset so she did not want that to happen again. When Resident #31's family asked to have her 7:30 P.M. Morphine and Ativan administered she informed them they would have to wait. She then administered the medications to Resident #31 around 8:00 P.M. and at that time Resident #31 was able to swallow medications. When Resident #31 was due for her at 10:00 P.M. Ativan and Morphine, she prepared the Ativan in some applesauce and entered the room to administer it. Hospice Nurse #210 told her not to put the applesauce in Resident #31's mouth because she was no longer coherent and would not swallow it. RN #107 confirmed she told her she was still placing the Ativan into her mouth and used a spoon to place the Ativan in applesauce in her cheek. At that point, Resident #31's daughter screamed at RN #107 and informed her to leave the room. She left the Morphine syringe with Hospice Nurse #210 and exited the room, counted her narcotic drawers with the nurse from the first floor, clocked out of the facility, and left the facility around 11:30 P.M. She reported Resident #31 was able to swallow at 8:00 P.M. and her mouth was open when she entered the room but could not answer questions related to the resident's cognitive status or her level of alertness when she returned for the 10:00 P.M. dose. Review of the facility policy Abuse, Neglect, Exploitation, and Misappropriation Prevention Program, revised April 2021, revealed residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraints not required to treat the resident's symptoms. The facility must identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property, or injury of unknown source, the (continued on next page)		

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

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NAME OF PROVIDER OR SUPPLIER Orrville Pointe		STREET ADDRESS, CITY, STATE, ZIP CODE 230 South Crown Hill Road Orrville, OH 44667	
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator is responsible for determining what actions are needed for the protection of residents. All allegations are thoroughly investigated. The Administrator initiates investigations. This deficiency represents non-compliance investigated under Complaint Number 3044559.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure medications were administered per physician orders. This affected one Resident (#25) of three residents observed and reviewed for medication administration. The facility census was 45. Findings include: Review of Resident #25's medical record revealed an admission date of 01/04/23. Diagnoses included paranoid schizophrenia, dementia, depression, Alzheimer's disease, impulse disorder, and delusions. Review of a care plan dated 02/24/26 revealed Resident #25 required Clozaril (antipsychotic medication) therapy due to severe schizophrenia. Interventions included to monitor and document the resident's response to Clozaril therapy and monitor the resident during medication administration to assure they are not pocketing medication. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #25 had impaired cognition. Resident #25 was dependent with toileting, transfers, and mobility. Review of the current physician orders for June 2026 revealed Resident #25 was ordered Clozaril 50 milligrams (mg) by mouth in the morning and Clozaril 100 mg by mouth at bedtime. Observation of medication administration on 06/11/26 at 7:35 A.M. with Licensed Practical Nurse (LPN) #124 for Resident #25 revealed she had obtained Resident #25's Clozaril medication card and the top of medication card indicated 100 mg was to be given at bedtime. LPN #124 proceeded to administer Resident #25's medications, which included administration of Clozaril 100 mg tablet. Follow up interview on 06/11/26 at 7:58 A.M. with LPN #124 and was asked to provide the medication card used to administer Resident #25's Clozaril. LPN #124 retrieved the medication card and confirmed the card was for Clozaril 100 mg and was to be administered at bedtime. LPN #124 was asked to check Resident #25's physician's orders and she then verified Resident #25's physician orders were to administer Clozaril 50 mg in the morning and Clozaril 100 mg at bedtime. LPN #124 confirmed the error and stated she had not noticed the top of the medication card was the 100 mg dose and was intended to be given at bedtime. Review of facility policy titled Administering Medications revised April 2019 revealed medications were to be administered in accordance with prescribers orders, medication errors were to be documented, reported, and reviewed by the Quality Assurance Performance Improvement (QAPI) committee and the individual administering the medication was to check the dosage. This deficiency represents non-compliance investigated under Complaint Number 3036496.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to prevent a significant medication error for Resident #31, when routine and as-needed medications for end-of-life comfort were unavailable for administration. This affected one Resident (#31) of five residents reviewed for medication administration. The facility census was 45. Findings include: Review of the medical record for Resident #31 revealed an admission date of 11/30/24. Diagnoses included chronic obstructive pulmonary disease, type two diabetes mellitus, and chronic respiratory failure with hypoxia. Resident #31 passed away at the facility on 06/13/26. Review of the care plan dated 04/20/26 revealed Resident #31 was experiencing a significant decline in health status related to terminal illness. Interventions included to administer all medications as ordered and provide a supportive, private environment for resident and family. Review of the five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 had a severe cognitive impairment with a memory problem and required extensive assistance for all activities of daily living. Review of the physician's orders dated 06/11/26 revealed orders to administer Morphine (an opioid analgesic commonly used for end-of-life comfort measures) 20 milligrams (mg)/5 milliliters (ml), administer 5 mg (0.25 ml) every four hours routine (scheduled for 12:00 A.M., 4:00 A.M., 8:00 A.M., 12:00 P.M., 4:00 P.M., and 8:00 P.M.) for respiratory distress, and an additional order for Morphine 5 mg (0.25 ml) every two hours as needed for respiratory distress. Resident #31 had an additional order dated 03/06/26 for Lorazepam (also known as Ativan, an antianxiety medication commonly used for end-of-life restlessness) 0.5 mg one tablet by mouth every 4 hours as needed for agitation, restlessness, or anxiety. Review of the outside hospice nursing note dated 06/11/26 authored by Hospice Nurse #210 revealed a facility nurse attempted to administer medications to Resident #31 crushed in applesauce. Resident #31 was unresponsive at the time with deep shallow respirations. Her respiration rate was 27 breaths per minute. Hospice Nurse #210 asked the facility nurse not to continue to attempt to administer oral medications as Resident #31 was no longer responsive and may aspirate the applesauce as she was mouth breathing. The facility nurse proceeded to place the applesauce in Resident #31's mouth when Resident #31's daughter verbally requested the nurse leave the room. The facility nurse handed Hospice Nurse #210 the Morphine syringe and told her to give it then. Hospice Nurse #210 administered Resident #31's Morphine dose at 10:00 P.M. and attempted to remove the applesauce out of Resident #31's mouth as she was not swallowing it and continued mouth-breathing. Hospice Nurse #210 then left Resident #31's room and went to speak to the facility nurse who was placing her cart in the closet stating she was leaving the facility. A follow up note authored by Hospice Nurse #210 revealed the facility nurse locked her keys in her cart and left the building. Resident #31's daughter had notified the Director of Nursing (DON). Hospice Nurse #210 indicated hospice staff would stay with Resident #31 until management staff arrived. Review of Resident #31's Medication Administration Record (MAR) for June 2026 revealed the routine dose of Morphine due at 06/12/26 at 12:00 A.M. was marked as not administered. Review of an outside hospice notes dated 06/12/25 at 2:43 A.M., 3:00 A.M., and 4:00 A.M. authored by (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hospice Nurse #225 revealed Hospice Nurse #225 took over care and was at Resident #31's bedside. The note referenced a locksmith arrived to the facility and gained entry to the medication cart at 2:52 A.M. The note referenced the DON and Licensed Practical Nurse (LPN)/Clinical Manager (CM) #101 was present in the facility working to obtain the resident's Morphine and Ativan. A subsequent note timed 3:00 A.M. revealed LPN CM #101 medicated Resident #31 with doses of Morphine and Ativan [on 06/12/26] at 3:00 A.M. for comfort and dyspnea. The note referenced after administration [on 06/12/26] at 3:30 A.M., Resident #31's respirations were now 16 (breaths per minute) and accessory muscle usage (the use of extra muscles in the neck, chest, and/or stomach to help with breathing; accessory muscle use indicates your primary breathing muscles such as the diaphragm are fatigued and signals the body is struggling to take in enough oxygen) had decreased. The note referenced Resident #31's family members remained at bedside and voiced concern regarding the patient's breathing pattern. Hospice Nurse #225 provided family education that it may take a few consistent doses of Morphine and Ativan for accessory [muscle] use to resolve, as Resident #31 went several hours without medications due to events in the facility earlier in the evening. Interview on 06/16/26 at 1:38 P.M. with the Administrator, Assistant Director of Nursing (ADON) #100, and LPN CM #101 revealed the Administrator reported she got a call around 10:00 P.M. [on 06/11/26] that Resident #31's family was very upset about the care RN #107 was providing. She reported she then reached out to her clinical staff and ADON #100 reached out to RN #107 and informed her to go administer the Morphine to Resident #31. Around 12:00 A.M., LPN/CM #101 then received messages that RN #107 could not be located in the facility. LPN/CM #101 reported she got dressed and went to the facility and began reaching out to RN #107 who would only respond by text message. RN #107 informed LPN/CM #101 that she had counted the medications with the other nurse working the first floor and locked the medication carts along with the keys in the second-floor medication room and left the facility. When MDS Nurse #100 arrived at the facility she had no keys to unlock the medication room. She notified the maintenance supervisor who then came to the facility around 1:00 A.M. He was able to unlock the medication room, but they could not unlock the medication carts. They reached out to the pharmacy who stated they could not send someone until the morning, so the staff reached out to a 24-hour locksmith who arrived at the facility around 2:30 A.M. He was able to get the medication carts unlocked around 3:10 A.M. and then they were able to administer medications to Resident #31. LPN CM #101 confirmed Resident #31 who was actively dying in hospice care did not receive their routine dose of Morphine due 06/12/26 at 12:00 A.M., nor any additional as-needed doses of any medications as no medications were available. Review of the facility policy titled Storage of Medications revised November 2020, revealed drugs and biologics were to be stored in a locked compartment and only persons authorized to prepare and administer medications were to have access to locked medications. Review of facility policy titled Administering Medications revised April 2019 revealed medications were to be administered in accordance with prescribers orders, medication errors were to be documented, reported, and reviewed by the Quality Assurance Performance Improvement (QAPI) committee and the individual administering the medication was to check the dosage. This deficiency represents non-compliance investigated under Complaint Number 3044559.		

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F 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of an emergency medical services (EMS) run report, review of hospital records, staff and family interviews, and facility policy review, the facility failed to ensure medications were appropriately secured and inaccessible to residents. This resulted in Immediate Jeopardy and serious life-threatening harm and negative health outcomes on 06/05/26 at approximately 9:00 A.M. when Resident #46 was observed to have multiple empty medication cards (packaged by pharmacy and provided specific labeling including the resident's name, medication name and dosage, and administration times) of Keppra (an anticonvulsant medication used to treat seizures) and Baclofen (a skeletal muscle relaxant and antispasmodic) each which had an original quantity of 30 and belonged Resident #11. Facility staff notified the physician who instructed staff to monitor the resident throughout the day. At approximately 7:45 P.M., while outside at a smoke break, Resident #46 experienced a change in condition and began vomiting a white, liquid substance. The physician was contacted and instructed staff to send Resident #46 to a local emergency department (ED) where she was evaluated and observed to have altered level of consciousness and required intubation and admission to the medical intensive care unit (MICU). Resident #46 remained in the MICU where she required mechanical ventilation, frequent monitoring, and intravenous (IV) hydration to address her medication overdose until she returned to the facility on the evening of 06/09/26. This affected one (#46) of three residents observed and reviewed for medication administration and storage. The facility identified 14 residents (#1, #2, #3, #5, #6, #9, #10, #11, #13, #14, #16, #17, #18 and #46) who were cognitively impaired and independently ambulatory on the secured unit. The facility census was 45. On 06/11/26 at 2:09 P.M., the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON) #100, Licensed Practical Nurse (LPN)/Clinical Manager (CM) #101, Corporate Registered Nurse (RN)/DON #192, and Corporate Minimum Data Set (MDS) Nurse #193 were notified the Immediate Jeopardy began on 06/05/26 at 9:00 A.M. when Resident #46 was found to have multiple empty medication cards of Baclofen and Keppra belonging to Resident #11 in her room. At approximately 7:45 P.M., Resident #46 was observed to have been vomiting a white substance, was lethargic and pale and was ordered to be sent to the hospital. Resident #46 was admitted for a drug overdose and admitted to the MICU and was intubated, received mechanical ventilation and IV fluids. Resident #46 was returned to the facility on [DATE]. The Immediate Jeopardy was removed on 06/06/26, when the facility implemented the following corrective actions: -On 06/05/26 at 3:27 P.M., LPN/CM #101 educated the facility's licensed nursing staff, which included eight RNs and 16 LPNs, via text message on medication storage safety requirements including maintaining medication cart security at all times, securing medication deliveries immediately upon receipt, preventing unauthorized resident access to medications, and reporting any medication security concerns immediately to facility leadership. All nursing staff replied to or acknowledged receipt of the education on 06/05/26. -On 06/06/26, an audit was completed by LPN/CM #101 of all locations where medications are stored and received within the facility and included the first-floor medication cart, the first-floor medication room, the second-floor medication cart, and the second-floor medication room. Additionally, the medication delivery totes and medication receiving process was reviewed with no concerns for medication storage identified. -On 06/06/26 at 9:00 A.M., LPN/CM #101 placed signage at the nurse's station reminding staff to lock medication carts when not in use, to appropriately store medication bins from pharmacy, and to not leave medications unattended in resident rooms. -On 06/06/26 at 9:00 A.M., all residents residing on the first floor (secured unit) underwent personal assessments to evaluate the residents' functional and behavior and room sweeps to look for any unsecured medications. No concerns were identified in the room (continued on next page)		

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F 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	sweeps; and no concerns were identified that residents had acquired medications that were not prescribed to them. All residents were assessed for deviations of functional and behavioral baselines. No concerns were identified. These assessments and room sweeps were conducted by LPN/CM #101. -On 06/06/26, the Administrator and DON implemented additional medication security, and the first-floor medication cart was to be locked in the first-floor medication room behind the nurses' station when not in use. This began on 06/06/26. -On 06/06/26, the Administrator and DON implemented additional medication security, and the second-floor medication cart was secured in a locked room (room [ROOM NUMBER]) when not in use. Maintenance applied a lock to room [ROOM NUMBER] on the morning of 06/06/26 with the on-duty floor nurse as the only nurse with access to the room. This began on 06/06/26. -Beginning on 06/06/26, the facility implemented ongoing audits of medication storage and security practices to include medication cart security observations, medication room security observations, medication delivery and receiving practices, and verification that medications are appropriately stored and secured when not in use. The DON or designee is responsible for completion of the audits. Audits were to be completed every shift (twice daily) for seven days, then three times weekly for one week, twice weekly for two weeks, and then once weekly for one week. The results of the ongoing audits would be reviewed in the facility's Quality Assurance and Performance Improvement (QAPI) program for further recommendations. -On 06/09/26, upon return from the hospital, Resident #46 was comprehensively assessed by LPN #129 and Resident # 46 was placed on facility-initiated 15-minute safety checks upon her return. The 15-minute checks are open-ended with no end date. -On 06/09/26, the Administrator coordinated a QAPI meeting to discuss and review the incident with Resident #46, the interventions in place, on-going systems for medication storage to prevent re-occurrence, reviewed the completed staff training and education, and how the staff believed the incident occurred. In attendance were the Administrator, DON, LPN/CM #101, Corporate MDS Nurse #193, Corporate RN/DON #192, Social Services Designee #102, Maintenance Director #157, and Business Office Manager (BOM) #103. -On 06/11/26, Resident #46's care plan was updated by Corporate MDS Nurse #193 to include the resident had a history of drug seeking behaviors and a history of taking medications that were not hers, stashing them in her clothing and in her room, and special care was needed when Resident #46 was around medication carts or where she could potentially have access to medications. Although the Immediate Jeopardy was removed on 06/06/26, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective actions and monitoring to ensure on-going compliance. Findings include: Review of Resident #46's medical record revealed an admission date of 09/01/25. Diagnoses included schizoaffective disorder, obsessive compulsive disorder (OCD), anxiety, impulse disorder, Attention-Deficit/Hyperactivity Disorder (ADHD), psychoactive substance abuse in remission, and delusional disorder. Review of the care plan dated 03/26/26 revealed Resident #46 exhibited behavioral symptoms that were not easily altered and were potentially harmful to herself and others including wandering with no discernable rational purpose, socially inappropriate/disruptive behaviors, non-compliance with ordered fluid restrictions, attempts to get others to get drinks for her, drinks her own urine, and drinks water out of the toilet. Care planned interventions included for staff to administer medications as ordered, monitor for adverse reactions to medications, monitor the resident's mood, affect and behaviors, encourage Resident #46 to verbalize feelings, and consult psychological services as needed. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #46 had a Brief Interview for Mental Status (BIMS) score of a 5, indicating severely impaired cognition. Resident #46 was noted to have hallucinations and delusions. Resident #46 was independent with eating, toileting, ambulation, and transfers. Review of Resident #46's current physician orders for June 2026 revealed her medication regimen did not include medication orders for Baclofen or Keppra. Review of a progress note dated 06/05/26 timed 9:41 A.M. authored by Registered Nurse (RN) #109 revealed multiple cards of an (unspecified) peer's (continued on next page)		

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F 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	medication were located in Resident #46's room, including one empty card of Baclofen and one empty card of Keppra. The note indicated the nurse was unable to determine if Resident #46 had taken the medications and Resident #46 denied taking the medications. Resident #46 was without signs/symptoms of distress, and a physical and mental assessment had been performed with no abnormal findings. The physician was notified and orders were received for a STAT (immediate) Keppra level. Review of a progress note dated 06/05/26 timed 10:50 A.M. authored by RN #109 revealed the laboratory called and stated they were unable to perform the STAT Keppra levels at that time and a Keppra level could only be completed on a routine laboratory day. The physician was notified. Review of progress note dated 06/05/26 timed 8:00 P.M. authored by RN #109 revealed that during smoke break Resident #46 vomited a white, liquid emesis. Resident #46 was returned to her room and was noted to be more lethargic than her baseline, difficult to arouse, and pale in color. The progress notes included Resident #46's vital signs were stable, she denied pain, nausea and denied taking any medications not prescribed to her. The note referenced the prior nurse (unspecified by name) had just administered her evening medications prior to her vomiting. The physician was notified and orders were received to send Resident #46 to the hospital for evaluation. Review of an EMS run report dated 06/05/26 revealed call received at 8:09 P.M. for poisoning/drug ingestion with a chief complaint of lethargy from a possible overdose of medication. The EMS narrative included EMS personnel were dispatched to the facility for a possible overdose on medication. Upon arrival, Resident #46 was found lying in bed alert to voice. Resident #46 had altered mental status and was observed to be pale. Staff reported to EMS that a room search had been done, and staff had found empty cards of Keppra and Baclofen and it was unknown the amount of each Resident #46 had taken. Staff reported to EMS personnel that during the morning Resident #46 seemed slightly off from her normal. EMS report further noted Resident #46 had altered mental status and was pale. EMS personnel transported Resident #46 to a local ED for evaluation. Review of a local hospital ED report dated 06/05/26 revealed Resident #46 was brought to the ED for a possible drug overdose after being found with multiple cards of medications from other patients. Upon arrival at the ED, Resident #46 was vomiting profusely and had a Glasgow Coma Scale (GSC, a scale used to objectively measure a person's level of consciousness in the three key areas of eye opening, verbal response, and motor response with a max score of 15 indicating normal alertness and orientation) score of eight, indicating a severe neurological emergency. The ED report indicated the resident was not alert, oriented, or answering questions appropriately. Resident #46 did not open her eyes to verbal or painful stimuli and could not state her name. ED staff called the facility to inquire about the medications Resident #46 potentially consumed, and facility staff reported to ED staff the two medications Resident #46 ingested were Keppra 750 milligrams (mg) extended release (ER) and Baclofen 10 mg tablets. After ED staff determined the resident consumed extended-release doses of Keppra, the ED physician called and spoke with poison control who indicated significant concern for Baclofen overdose, indicating the maximum daily dose is 80 mg, and Resident #46 potentially consumed 300 mg. Poison control indicated patients with a Baclofen overdose almost always required intubation and patients can exhibit signs that look like brain death for several days which include coma and flaccidity. Poison control indicated with a Keppra overdose the patient will likely have a lot of vomiting and central nervous system (CNS) depression making her at high risk for aspiration. During the ED evaluation, Resident #46 became combative with ED staff and due to concerns the resident could not safely maintain her airway, the decision was made to intubate the resident. Just prior to intubation, the resident was not responding to stimuli and her GCS score decreased down to a 7, indicating a continued neurological emergency. Resident #46 was intubated and sedated and mechanical ventilation was initiated. The ED report indicated there were no antidotes to the medications she consumed, and the resident would require intensive care unit (ICU) admission while she metabolized the medications. Resident #46 was transferred to another hospital with MICU availability in the early morning hours of 06/06/26. Review of hospital paperwork dated 06/06/26 to 06/09/26 revealed (continued on next page)		

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F 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #46 was admitted to the hospital from an affiliated ED with diagnoses including drug overdose on Keppra and Baclofen, acute toxic encephalopathy related to a drug overdose, and acute respiratory failure on mechanical ventilation. From 06/06/26 to 06/08/26, Resident #46 required mechanical ventilation and MICU care, including frequent monitoring, laboratory testing every six hours, and IV hydration. Resident #46 was extubated on 06/08/26 and monitored for another day. The records indicated Resident #46 saw a psychiatry provider who recommended she return to her locked facility on discharge. Hospital records dated 06/09/26 revealed Resident #46 denied recollection of the incident and was transferred back to the facility on the evening of 06/09/26. Interview on 06/09/26 at 7:20 A.M. with LPN #118 revealed she had been informed Resident #46 had multiple empty medication cards in her room, one was Keppra and the other was Baclofen that had belonged to Resident #11. LPN #118 stated the staff had performed routine random room sweeps of Resident #46's room because she had hoarding behaviors and had been known to take items and hide things. LPN #118 stated Resident #46 was ambulatory and would pace quickly in the halls throughout the day and night. LPN #118 stated that on 06/05/26 during the evening smoke break, Resident #46 had thrown up and was sent to the hospital but was unsure why Resident #46 had not been sent to the hospital sooner. LPN #118 stated she was unsure how Resident #46 had obtained the medications; however, Resident #46 was sneaky and would take anything that was out. Interview on 06/09/26 at 7:46 A.M. with Behavioral Specialist (BS) #191 revealed she was present at the facility on 06/05/26 when, at approximately 9:00 A.M., Certified Nursing Assistant (CNA) #132 had informed her of finding an empty medication card in Resident #46's room. BS #191 stated she immediately went into Resident #46's room and she had also observed an additional empty medication card of Keppra on the nightstand. BS #191 stated she had also observed two other medication cards that the top portions were ripped off that would have included the medication and the residents name, and due to the information missing she was unable to state what the two additional medication cards were. BS #191 stated she had concerns later that morning regarding how high Resident #46 had looked and stated she had taken a picture of Resident #46 at that time. Observation of the picture she had taken of Resident #46 at time of interview revealed the photo was taken on 06/05/26 at 10:39 A.M. and Resident #46 had glassy eyes that were half open and the resident appeared disheveled and appeared to be under the influence. BS #191 stated the picture was not how Resident #46 normally appeared. BS #191 stated she had informed RN #109 at that time and stated there was no administrative staff present in the facility to further inform. Interview on 06/09/26 at 10:34 A.M. with CNA #132 revealed she had done a random room search of Resident #46's room on 06/05/26 at approximately 9:00 A.M. and stated she had observed Resident #46's blankets looked weird on her bed. CNA #132 stated as she removed the blankets, she observed an empty medication card of Baclofen along with some loose pills. CNA #132 stated she had alerted BS #191, who then entered Resident #46's room and an additional empty medication card was found; however, she was unsure what the additional medication card was. CNA #132 stated she had observed the dispense date of the Baclofen card of 06/01/26 and the other medication card had a dispense date of 05/28/26. CNA #132 stated BS #191 had informed RN #109. CNA #132 stated later that morning she had noticed that Resident #46 had been walking slower than normal and her pupils were huge. CNA #132 stated BS #191 noticed changes with Resident #46 as well and had taken a picture of her. CNA #132 stated Resident #46 was definitely altered and stated she had asked RN #109 about sending Resident #46 out [to the hospital] and RN #109 had not provided her with a response. Telephone interview on 06/09/26 at 11:07 A.M. with RN #109 revealed she was Resident #46's assigned nurse on the morning of 06/05/26 at approximately 9:00 A.M. when BS #191 informed her of the multiple empty medication cards found in Resident #46's room. RN #109 stated Resident #46 had denied she had taken the medications and stated she had performed an assessment and Resident #46 was within her normal baseline. RN #109 stated BS #191 had shown her the photograph she had taken that morning; however, Resident #46 had appeared normal to her. RN #109 stated she had left the facility at approximately 1:00 P.M. and had returned at (continued on next page)		

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F 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8:00 P.M. During the smoke break at approximately 8:00 P.M., a (unspecified) CNA had told her Resident #46 was outside throwing up. RN #109 stated she had called the physician who had given her orders to send Resident #46 to the hospital. Interview on 06/09/26 at 11:25 A.M. with LPN/CM #101 revealed she worked at the facility on 06/05/26 from approximately 4:00 A.M. to 9:00 A.M. LPN/CM #101 stated she had administered Resident #46 her morning medications at approximately 6:00 A.M. with no concerns. LPN/CM #101 stated after she had left the facility, she had received calls from BOM #103 and BS #191 between 9:13 A.M. and 9:15 A.M. LPN/CM #101 stated she had returned the call to BOM #103 and had been informed of the medication cards found in Resident #46's room. LPN/CM #101 stated she returned to the facility at approximately 11:00 A.M. following the call with BOM #103. LPN CM #101 stated once she returned to the facility, she observed the medication cards and stated she had attempted to reach the Administrator, who had not answered and stated she called DON #192 from their sister facility. LPN/CM #101 stated she had assessed Resident #46, and she was within her normal baseline. LPN/CM #101 stated she had kept an eye on Resident #46 all throughout the day with no concerns. LPN/CM #101 stated during the day (couldn't recall timeframe) staff had reported Resident #46 wasn't acting normal and had slurred speech; however, when she assessed Resident #46, she had not observed any concerns and stated sometimes the aides overreact. LPN/CM #101 stated she had obtained vital signs and neurological checks throughout the day, and all were within normal limits, however she had not documented the findings in the electronic medical record system. LPN/CM #101 stated she was unsure how Resident #46 had obtained the medications and speculated the medication cart had been left unlocked. LPN/CM #101 had further stated she had spoken with the Administrator at 10:10 A.M. and had informed her of the situation and was advised to conduct a room search and call the physician and to keep her updated on the situation. LPN/CM #101 stated during the evening smoke break between 7:45 P.M. and 8:00 P.M., the CNAs had informed her Resident #46 had thrown up and stated she had advised RN #109 to obtain vital signs and assess Resident #46. LPN/CM #101 stated she had assisted with assessing Resident #46 at that time and Resident #46 was not speaking clearly, mumbling, and was having difficulty keeping her eyes open. LPN/CM #101 stated she had then called the physician who advised the nurse to send Resident #46 to the hospital. Interview on 06/09/26 at 12:30 P.M. with DON #192 revealed she worked for a sister facility and had received a call from LPN/CM #101 on the morning of 06/05/26 (couldn't recall the time) and had been informed two empty medication cards had been found in Resident #46's room. DON #192 stated she had advised staff to perform a room sweep, a full assessment, and call the physician and Resident #46's guardian. DON #192 stated she was not made aware how Resident #46 had obtained the medications and she had not been informed of any abnormal behaviors. DON #192 stated she had received a call later that evening around 8:00 P.M. that Resident #46 was vomiting after she received her evening medications and DON #192 had agreed it was appropriate to have Resident #46 taken to the hospital. Interview on 06/09/26 at 12:50 P.M. with BOM #103 revealed at approximately 9:00 A.M. on 06/05/26, BS #191 had brought her multiple empty medication cards of Baclofen and Keppra. BOM #103 stated she had immediately called the Administrator, the DON (who had not answered), and DON #192 who had advised calling the physician, have the staff do an assessment, contact the physician, and have the staff perform a medication error report. BOM #103 stated once LPN/CM #101 had arrived she had given the medication cards to her and had told her what DON #192 had advised. BOM #103 stated she saw Resident #46 during the morning, and she appeared more tired than normal and was groggy. Interview on 06/09/26 at 3:22 P.M. with the DON revealed he had worked the morning of 06/05/26 until approximately 4:00 A.M. and had not observed any concerns with Resident #46. The DON stated he had left the facility and had gone home to sleep and when he woke up (couldn't recall time) he had a text message from LPN/CM #101 and the Administrator but did not have any record he responded. The DON stated he had returned to the facility on [DATE] and an investigation had been started that was still ongoing. The DON stated the facility was unable to state how Resident #46 had obtained the medications and stated it was likely (continued on next page)		

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F 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	from the medication cart having been unlocked or the medications possibly having been left on top of the cart. Interview on 06/10/26 at 7:49 A.M. with ADON #100 and LPN/CM #101 revealed ADON #100 stated she had received a text message from LPN/CM #101 on 06/05/26 at 8:46 P.M. that stated, I need to tell you something. ADON #100 stated she then called LPN/CM #101, who advised her that Resident #46 was found with multiple empty medication cards in her room and that Resident #46 was being taken to the hospital. ADON #100 did not provide any additional information. Observation on 06/10/26 at 9:24 A.M. revealed Resident #46 was seated in a reclining chair in a common area. She was observed to quickly stand up and began pacing the hallways. Interview with Resident #46 at the time of the interview revealed non-sensical phrases and when asked why she was recently at the hospital, she was unable to respond and continued to pace the hallways. Telephone interview on 06/10/26 at 11:05 A.M. with Physician #194 revealed he had received a call from the facility and had been informed staff found multiple empty medication cards in Resident #46's room that had belonged to another resident. Physician #194 stated he had advised the staff to perform frequent vitals (every three hours), obtain STAT Keppra levels, and to keep an eye on the resident. Physician #194 stated he had asked facility staff how Resident #46 had obtained the medication cards and he had been told they were still investigating. Physician #194 stated he had received a call later that evening around approximately 8:00 P.M. that Resident #46 had a change in mental status and advised staff to send Resident #46 to the hospital. Physician #194 stated he had been caring for Resident #46 for several years and stated she was sneaky and slick and would make a great pick pocket. Physician #194 stated symptoms of an overdose of Baclofen may not present from 6-8 hours after ingestion and stated Keppra may take a little longer as it was a long-acting medication, and stated signs of an overdose would likely include a change in mental status. Physician #194 stated he had not been made aware of the outcome of the investigation and stated he did not expect the investigation to have taken this long to complete. Interview on 06/10/26 at 2:30 P.M. with the DON revealed the investigation was still ongoing, and they had not been able to determine how Resident #46 had obtained the medication cards. The DON reported so far, he had only gathered staff statements and had not yet followed up with Physician #194 as the investigation was ongoing. Interview on 06/10/26 at 2:51 P.M. with LPN/CM #101 revealed she had sent a text message to the nursing staff on 06/05/26 at 3:27 P.M. regarding the securing of medication carts. Interview on 06/10/26 at 4:01 P.M. with LPN #118 revealed she had spoken with Resident #46 on the afternoon of 06/10/26, and Resident #46 informed her of how she had obtained the medications. LPN #118 stated Resident #46 had stated when the DON and CNA #195 had been working she had taken the pills from the unlocked medication cart and stated she wanted vitamins. Interview on 06/10/26 at 4:10 P.M. with CNA #195 revealed she had spoken with Resident #46 on 06/10/26 during the 3:00 P.M. smoke break and Resident #46 stated she had taken the medication from the medication cart while she and the DON were sitting at the nurses' station. CNA #195 stated she had worked with the DON on the evening of 06/04/26 from 2:30 P.M. to 10:30 P.M. CNA #195 stated on 06/04/26, she had searched Resident #46's room at approximately 5:00 P.M. as she was helping Resident #46 look for her missing vape and she had not found any medications. CNA #195 stated she asked Resident #46 how she had gotten the medications and Resident #46 had stated the medication cart was unlocked and she just took them. Interview on 06/11/26 at 9:00 A.M. with LPN/CM #101 revealed she had performed cart audits on 06/05/26, and posted signs at the nurses' station to remind nurses to ensure medications carts were always secured. LPN/CM #101 stated staff had not spoken with Resident #46 since her return from the hospital and stated ADON #100 had a better rapport with Resident #46, and she would speak with her. Observation of an interview on 06/11/26 at 9:24 A.M. revealed ADON #100 and LPN/CM #101 interviewed Resident #46 in her room. ADON #100 asked Resident #46 how she had gotten the medications and Resident #46 was heard stating, I was quiet as a mouse. Resident #46 additionally stated the medication cart was unlocked and she needed vitamins. Follow up interview on 06/11/26 at 9:37 A.M. with ADON #100 and LPN/CM #101 regarding their interview with Resident #46 revealed (continued on next page)		

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F 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #46 had stated while the DON and CNA #195 were at the nurses station the cart was unlocked and she was quiet as a mouse and took the medications from the bottom drawer of the unlocked medication cart because she know staff did not get in there all the time. At the time of the interview, the DON entered and stated he had just been made aware of Resident #46's account of how she obtained the medications. The DON stated he had worked with CNA #195 on the evening of 06/04/26 until about 10:30 P.M. and stated he recalled having sat at the nurses' station with CNA #195 during that evening. The DON stated he could not state if the medication cart had been left unlocked and stated the medication cart usually was placed outside of the nurses' station. The DON denied seeing Resident #46 approach the medication cart during the evening of 06/04/26. Follow up interview on 06/11/26 at 11:39 A.M. with CNA #195 revealed she had again spoken with Resident #46 about the situation later in the evening of 06/10/26 and Resident #46 had provided additional information that included Resident #46 stated to CNA #195 that she was observant and she watches staff. CNA #195 further stated Resident #46 had told her she kept the medications in her jacket's double liner. Interview on 06/11/26 at 1:27 P.M. with Resident #46's Guardian revealed she had just completed a care conference with the DON, Administrator, ADON #100, and LPN/CM #101 who informed her of the follow-up regarding the incident on 06/05/26. The Guardian stated in the meeting, the DON indicated he may have left his medication cart unlocked and Resident #46 had obtained the medication without his knowledge. Review of the facility policy titled Storage of Medications revised November 2020, revealed drugs and biologics were to be stored in a locked compartment and only persons authorized to prepare and administer medications were to have access to locked medications. Compartments containing drugs and biologicals are to be locked when not in use and unlocked medication carts are not to be left unattended. This deficiency represents non-compliance investigated under Complaint Number 3036496.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain an accurate and complete medical records which included documentation of resident to resident altercations. This affected two residents (#6 and #47) of three residents reviewed for abuse. The facility census was 45. Findings include: 1. Review of Resident #6's medical record revealed an admission date of 12/22/25. Diagnoses included depression, bipolar disorder, and mood disorder. Review of a care plan dated 01/16/26 revealed Resident #6 was prone to anger and aggression and had poor coping skills and due to serious mental illness and underdeveloped coping skills, anger is often misplaced on others. Interventions included be attentive to angry and aggressive behaviors, use appropriate word choices and tone of voice, set limits on specific behavior, document all behaviors and their responses to interventions. Resident #6 was at risk for behaviors that can be physically or emotionally harmful to self or others that included physical altercations with others. Interventions included intervene early to calm resident and defuse potential incident. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 had intact cognition. Resident #6 required supervision with eating, toileting, bathing and was independent with ambulation. Review of Resident #6's progress notes from 06/08/26-06/22/26 revealed no documentation indicating the resident had been involved in any resident to resident altercations. 2. Review of Resident #47's medical records revealed an admission date of 06/16/26. Diagnoses included post traumatic stress disorder, anxiety, and schizophrenia. Review of a care plan dated 06/16/26 revealed Resident #47 had behavioral symptoms not easily altered and potential harmful to others and had false ideas and had become agitated at times with staff and residents. Interventions included offer non-pharmacological interventions including calming touch, 1:1 distraction and removing from overstimulating environments. Review medications with the physician to ensure the resident is at behavioral baseline, administer medications as ordered, monitor mood and behaviors, and monitor for increased stimulation that may trigger agitation. Review of the MDS assessment dated [DATE] revealed Resident #47 had intact cognition. Resident #47 was recorded to have verbal and physical behaviors and delusions. Resident #47 required supervision with toileting, bathing and ambulation. Review of Resident #47's progress notes from 06/16/26-06/21/26 revealed no documentation indicating the resident had been involved in any resident to resident altercations. Telephone interview on 06/22/26 at 9:10 A.M. with Certified Nursing Assistant (CNA) #132 revealed on the evening of 06/13/26 between approximately 6:30 P.M. and 7:30 P.M., Licensed Practical Nurse (LPN) # 125 had made her aware Resident #47 had punched Resident #6 in the head with her fist. CNA #132 stated she had not witnessed the altercation and she had not observed any injuries to Resident #6. Interview on 06/22/26 at 11:18 A.M. with LPN/Clinical Manager (CM) #101 revealed she had not been made aware of an altercation between Resident #6 and Resident #47. LPN/CM #101 stated if an altercation would have occurred, a progress note should have been written that included information regarding the incident and notification to the physician and family/guardian. LPN/CM #101 had reviewed Resident #6's and #47's medical records and confirmed no documentation regarding any altercations was in either record. LPN/CM #101 further stated if an altercation would have occurred, a risk assessment should have been completed. LPN/CM #101 had reviewed the risk assessments and had located one created on 06/13/26 (untimed) by LPN #125. LPN/CM #101 confirmed the risk assessment was not complete and had not included any information of the alleged incident. Interview on 06/22/26 at 11:33 A.M. with the Director of Nursing (DON) revealed he had not been made aware of any altercations involving Resident #6 and #47 on 06/13/26. DON stated if a resident to resident altercation had occurred, there should have been a progress note written regarding the incident and notification to the physician and family/guardians. The DON further confirmed the risk assessment dated [DATE] completed by LPN (continued on next page)		

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#125 was not complete and had not included any specific information or notification to the physician or guardian. Interview on 06/22/26 at 12:50 P.M. with Resident #6 revealed a few weeks ago as she was ambulating in the hallway Resident #47 had punched her in the face. Resident #6 stated no staff were present to witness the altercation, however she had told an (unspecified) aide a little while after about what had occurred. This deficiency represents non-compliance investigated under Complaint Number 3047818.		