STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366220	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Court Rehab and Nursing	6969 Glenmeadow Lane Cincinnati, OH 45237

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** :THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENCE OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY Based on record review, staff interview, review of facility Self-Reported Incidents (SRI), review of the facility investigation, review of the local weather report, and review of the facility policy, the facility failed to provide adequate supervision to prevent a cognitively impaired resident from eloping from the facility. This resulted in Immediate Jeopardy when Resident #70 left the facility without staff knowledge, was missing approximately three hours and was found approximately 0.8 miles from the facility by a facility staff member before returning to the facility. This affected one (Resident #70) of three residents reviewed for risk of elopement. The facility identified 26 residents at risk for elopement. The facility census was 101. On 04/02/26 at 1:05 P.M. the Administrator, Director of Nursing (DON), and Director of Clinical Operations (DCO) were notified Immediate Jeopardy began on 10/11/25 at 8:55 P.M. when Resident #70's wife called the facility and reported to Licensed Practical Nurse (LPN) #281 that Resident #70 was not in the facility. He had called his wife from his personal cell phone stating he was at a bus stop. LPN #281 transferred Resident #70's wife's call to Registered Nurse (RN) #282 who was working the 400 Unit, a secured memory care unit. RN #282 did not answer the phone. LPN #281 did not take any further action to report or search for the missing resident. On 10/11/25 at 9:20 P.M., Resident #70's wife called back and asked LPN #281 if the staff had located the resident. LPN #281 then physically went to the 400 Unit to inform RN #282 Resident #70 was reportedly not in the facility. Certified Nursing Assistant (CNA) #280 and RN #282 realized Resident #70 was not on the secure memory care unit and began searching for him throughout the facility. At 9:45 P.M. CNA #280 reported to the night shift supervisor, LPN #219, that Resident #70 was missing. Staff began searching for Resident #70 outside the perimeter of the building and were unable to locate the resident. At 10:05 P.M. LPN #219 searched the neighborhood in his private vehicle and returned to the facility at 10:21 P.M. unable to locate Resident #70. At 10:38 P.M., RN #282 notified the Assistant Director of Nursing (ADON), the Director of Nursing (DON), and the Administrator that Resident #70 was missing. No one from the facility notified local police to assist in the search for Resident #70. At 10:50 P.M., RN #282 searched the neighborhood in his private vehicle and at 11:03 P.M. returned to the facility with Resident #70, who was found 0.8 miles away from the facility at a bus stop on the other side of a four-lane road. At 11:30 P.M. the Administrator checked the Unit 400 egress door which was functioning properly, but the secondary screamer alarm was buzzing softly and not sounding loudly enough to alert staff when a resident exited the door. The Immediate Jeopardy was removed on 10/12/25 and continued at a Severity Level 2 (no actual harm with potential for more than minimum harm that is not Immediate Jeopardy) until it was subsequently corrected on 10/26/25 when the facility implemented the following corrective actions: On 10/11/25 at 11:03 P.M., RN #282 returned to the facility with Resident #70. RN #282 and the ADON assessed Resident #70, who was at his baseline with no injuries noted. Resident #70 was placed on one-on-one supervision immediately upon his return to the facility and remained on one-on-one supervision for the next 72 hours. On 10/11/25 at 11:05 P.M., RN #282 (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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	notified Resident #70's wife and the Medical Director (MD) that Resident #70 was located and returned to the facility. On 10/11/25 at 11:15 P.M., the DON and ADON completed a full facility head count with no missing residents. On 10/11/25 at 11:30 P.M., the Administrator changed the battery to the Unit 400 egress door so the secondary screamer alarm to the door would sound loudly if anyone tried to exit the door. The Administrator also checked the other secured doors, and all were functioning properly. The Administrator also checked Unit 400 windows and found no windows had been broken and all windows on the unit remained secure. On 10/12/25 beginning at 12:30 A.M., the DON and ADON begin immediate education with the staff present in the facility to reeducate them on the Elopement Wandering Management Protocols/Missing Person policy and the Resident Abuse, Neglect, Misappropriation of Resident Property and Injury of Unknown Origin policy. Education also included responding immediately regarding a report of a missing resident and the importance of not leaving the secured units unattended. Education continued for current staff and was completed on 10/12/25 unless they were either on vacation, paid time off (PTO), or sick leave. Current staff were notified via the OnShift scheduling messaging system that prior to the start of their next scheduled shift they had to contact the Administrator, the DON, or the ADON before accepting an assignment. Education continued for all new employees during orientation and as needed. The DON and the ADON also gathered staff statements regarding the incident. The training was completed with the staff working the 7:00 P.M. to 7:00 A.M. shift by 1:00 A.M. on 10/12/25. The weekend RN Supervisor #283 continued to educate staff on both shifts on 10/12/25 and all training was finished at approximately 7:30 P.M. on 10/12/25. On 10/12/25 at 10:30 A.M., the Maintenance Director changed the codes on all secured units and egress doors. On 10/12/25, the Administrator and the ADON terminated employment for RN #282 and for CNA #280. Both employees were terminated for falsification of records and for giving misleading information during an investigation. Initially, RN #282 told administration Resident #70 had been found outside the building when the resident was found 0.8 miles away from the facility. On 10/12/25, the DON reported RN #282 to the to the Ohio Board of Nursing for falsification of records. On 10/12/25, the DON reported CNA #280 to the Ohio Nurse Aide Registry for falsification of records. On 10/12/25, the DON interviewed Resident #70 about the elopement and the resident said he watched the enemy flow of the enemy and then used them for cover, waited for the right time, grabbed his jacket, and then slipped into the night. On 10/12/25, at 10:30 A.M., the DON completed updated elopement assessments/evaluations for all current residents on secured units (the 100 Unit, the 200 Unit, the 400 Unit) The also DON reviewed elopement binders for all units and updated them as needed. On 10/12/25, the Maintenance Director/Designee began auditing all secured doors and alarms five times per week for four weeks, then weekly for four weeks and then monthly ongoing. Review of the audit reports revealed audits were conducted on the following dates: Week One-10/12/25, 10/13/25, 10/14/25, 10/15/25, 10/16/25, 10/17/25, Week Two-10/20/25, 10/21/25, 10/22/25, 10/23/25, 10/24/25, Week Three-10/27/25, 10/28/25, 10/29/25, 10/30/25, 10/31/25, Week Four-11/3/25, 11/4/25, 11/5/25, 11/6/25, 11/7/25, Month One-11/20/25, 11/26/25, Month Two-12/3/25, 12/9/25, 12/16/25, 12/22/25, 12/30/25, Month Three 1/1/26, Month Four- 2/4/26, Month Five- 03/03/25. On 10/13/25, the Administrator began questioning five randomly selected staff members regarding elopement and missing person protocols. This was completed once weekly for four weeks. Review of the documentation revealed the performance monitoring was conducted on the following dates: Week One-10/13/25, 10/14/25, 10/15/25, 10/16/25, 10/17/25, Week Two-10/20/25, 10/21/25, 10/22/25, 10/23/25, 10/24/25, Week Three-10/27/25, 10/28/25, 10/29/25, 10/30/25, 10/31/25, Week Four-11/03/25. On 10/13/25 at 3:00 P.M., an ad hoc Quality Assurance Performance Improvement (QAPI) meeting was held with participation of the Administrator, the DON, the Medical Director and a member of the Governing Body (the DCO) to review and discuss the incident involving Resident #70 and a plan of action. On 10/13/25, the Administrator and the DON completed a root cause analysis of Resident #70's elopement and determined that a delayed response by staff in identifying the residents' absence and (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	notifying the appropriate individuals resulted in an extended duration of the resident being missing. The prompt return of the residents could have been achieved through quicker identification and notification. It was also found that the Unit 400 egress secondary screamer alarm buzzed softly until the battery was replaced, which would have allowed a person to exit the unit without alerting staff. Beginning on 10/16/25, ongoing monitoring and education elopement drills were conducted at varying times weekly for four weeks and then quarterly thereafter. Review of the audit reports revealed elopement drills were conducted on the following dates and times: 10/16/25 at 3:58 PM P.M., 10/17/25 at 3:20 P.M., 10/31/25 at 2:59 P.M., 11/5/25 at 9:00 A.M., 02/10/26 st 2:20 P.M. There were no negative findings during any of the drills. The facility will continue with quarterly elopement drills. By 10/19/25, the Maintenance Director installed an additional camera for the 400 unit. Observation on 04/06/26 revealed a camera at the entrance to unit 400 pointing down the hallway to the egress door. By 10/19/25, the facility purchased three additional cordless phones to aid staff with rapid communication in the event of an elopement. On 04/02/26, review of the medical records for two additional Residents #9 and Resident #57 reviewed for elopement, revealed no concerns.^ On 04/06/26, random observations of Resident #70, Residents #9, and Resident #57, revealed elopement interventions were in place and residents were not actively exit-seeking. On 04/01/26 and 04/02/26 between 8:00 A.M. and 3:30 P.M., staff interviews were conducted with CNAs #272, #133, LPNs #225, #237, and MA #241, which confirmed staff were knowledgeable about the procedures to follow if a resident eloped from the facility and the need to reassess residents for elopement risk if they had a change in condition such as increased wandering behaviors and/or exit-seeking behaviors. Interview on 04/06/26 at 10:00 A.M. with the DCO and the Administrator confirmed the facility has had no further elopements since Resident #70's elopement on 10/11/25. Findings include: Record review revealed Resident #70 was admitted on [DATE] with diagnoses including dementia, hypertension, major depressive disorder, and diabetes mellitus type two. Review of the admission baseline care plan for Resident #70 dated 10/06/25 revealed the resident was assessed as being at risk for elopement and should reside in a secured unit due to cognitive impairment and wandering tendencies. Review of the nurse progress note for Resident #70 dated 10/12/25 at 2:23 A.M. per RN #282 revealed on 10/11/25 at 11:00 P.M., Resident #70 was discovered missing during a routine check. Resident #70 was found outside the door and escorted inside. Resident #70 reported to the nurse he had been out looking for his car. A head-to-toe assessment of Resident #70 revealed the resident had no injuries, was alert and oriented to person and place which was the resident's baseline, and vital signs were within normal limits. Resident #70 was placed on one-on-one supervision. The nurse notified management, the resident's wife, and the resident's medical provider with no new orders noted. During an interview on 04/01/26 at 5:26 P.M., the ADON stated she received a call from RN #282 on 10/11/25 at approximately 10:00 P.M. reporting Resident #70 was missing from the facility. The ADON stated she told RN #282 to check all the rooms then called the DON and the Administrator to notify them of the missing resident. While the ADON was in transit to facility, RN #282 called and reported Resident #70 had been found right outside the door to the unit. The ADON arrived shortly before 11:00 P.M. and went immediately to the 400 Unit, but neither Resident #70 nor RN #282 were on the unit. The ADON then opened the egress door to the 400 unit using the code, but the screamer alarm on the door buzzed softly and was not loud enough to alert staff. RN #282 and Resident #70 then arrived on the unit. The ADON and RN #282 assessed Resident #70 for injuries. He was not injured. The ADON asked RN #282 to go outside with her to show her the exact location where the RN had found Resident #70. RN #282 indicated Resident #70 was at a bus stop adjacent to the Captain D's restaurant across Reading Road which was a four-lane road, 0.8 miles from the facility. The Administrator arrived and checked the camera footage from the facility camera in the 400 unit which revealed staff began searching for Resident #70 two hours prior to any call to management. Review of the camera footage also revealed RN #282 and CNA #280 had left the unit unattended during the time Resident #70 exited the building. The ADON verified RN #282 and CNA #280 were the only staff (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	assigned to the 400 unit at the time of Resident #70's elopement. RN #282 and CNA #280 were on a different unit at the time of the elopement. The ADON confirmed the facility had a policy to never leave a secured unit unattended. The ADON confirmed RN #282 changed his version of the events surrounding Resident #70's elopement multiple times. During an interview on 04/01/25 at 4:50 P.M., the DON stated the ADON notified her by phone of Resident #70's elopement on 10/11/25 at approximately 11:00 P.M. The DON stated she then notified the Administrator and the DCO by phone of the elopement. The DON stated when she arrived at facility on 10/11/25, Resident #70 was back in the unit, had been assessed and placed on one-on-one supervision. RN #282 then reported to the DON that Resident #70 had been found outside, across a field, off the property about 0.8 miles from the facility and on the other side of a four-lane road at a bus stop near Captain D's restaurant on Reading Road. The DON stated multiple staff interviews confirmed they had heard no alarms sounding at any time while Resident #70 was missing. During a second interview on 04/02/26 at 11:37 A.M., the DON stated she expected staff to contact her and the Administrator immediately when a resident was missing from the facility. The DON stated when staff contacted her on 10/11/25 at 10:00 P.M. to report Resident #70 as missing they did not share the resident's wife had reported him missing at 8:55 P.M. The DON further stated calling the police for assistance did not occur to her at the time, because the ADON lived less than 20 minutes from facility and would arrive soon to manage the situation. The DON verified the staff failed to follow the missing persons policy by failing to immediately call a code E designating an elopement and failed to immediately notify management, the resident's physician and the local authorities. During an interview on 04/02/25 at 9:47 A.M., the Administrator stated when RN #282 found Resident #70 on 10/11/25, the resident was dressed appropriately for the weather and was wearing a red shirt, pants, shoes with socks and had a jacket with him. During an interview on 04/02/26 at 9:49 A.M. by telephone, LPN #237 stated she had worked on the 100 unit on 10/11/25 from 7:00 P.M. to 7:00 A.M. LPN #237 stated when she returned from lunch around 10:00 P.M. staff told her Resident #70 was missing and she went to the 400 unit to see if she could help. LPN #237 then went out the back door with CNA#280 and RN 282 to look for Resident #70 outside the building, but they could not find him. During an interview on 04/06/26 at 1:40 P.M., the DCO stated the DON notified him of Resident #70's elopement on 10/11/25 at approximately 11:00 P.M. The DCO verified he actively participated in the ad hoc QAPI meeting the facility held on 10/13/25 where they reviewed and discussed the incident involving Resident #70 and developed a plan of action. Review of the online weather report dated 10/11/25 at 9:00 P.M from Weather Underground revealed in Cincinnati, Ohio the air temperature during the time Resident #70 was missing from the facility was 56 degrees Fahrenheit (F) with no precipitation and a wind speed of approximately five miles per hour. Review of the facility incident investigation report for Resident #70 dated 10/13/25 revealed the resident was last seen in the facility on the unit on 10/11/25 at 8:00 P.M. and was reported missing by the resident's wife at 8:55 P.M. The investigation determined Resident #70 likely exited the facility when the unit was unattended by staff via 400-unit egress door around 8:30 P.M. The screamer feature to the 400-unit door did not sound loudly because the battery needed to be replaced. Staff found Resident #70 out of the facility off the facility grounds and returned the resident back to facility unharmed at 11:03 P.M. Review of the facility SRI regarding Resident #70's elopement initiated 10/11/25 and completed 10/17/25 revealed the facility substantiated an allegation of neglect of the resident per RN #282 and CNA #280. Review of the facility policy titled Missing Person Policy dated July 2020 revealed the facility staff should take the following actions immediately upon discovery of a missing resident: the supervisor will notify all staff of the missing resident by paging code E for elopement, staff will complete a thorough search of the facility, report the missing resident to the Administrator, the DON, the physician, and the resident's representative/family, notify the police department, provide the police department with a picture of the resident, medication list, history of resident and possible locations/areas he may have gone to in the past, and description of what the resident is wearing, etc., notify local hospitals, continue to search the interior and exterior grounds of (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	facility and as other areas as designated by the administrative staff, document the proper sequence of events thoroughly in the resident record. This deficiency represents non-compliance investigated under Complaint Number 2648926 and Complaint Number 1348234.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on medical record review, observation, staff interview, review of pharmacy guidelines, and review of the facility policy, the facility failed to ensure insulin vials were properly labeled and stored. This affected five Residents (#26, #55, #85, #86 and #99) of the 24 residents with medications stored in the unit-100 medication cart. The facility census was 101 residents. Findings include: 1.Review of the medical record for Resident #26 revealed an admission date of 09/12/24 with diagnoses of diabetes mellitus type two and chronic kidney disease. Review of the physician's orders for Resident #26 revealed an order dated 09/04/25 for Degludec insulin 10 units at bedtime. Review of the Medication Administration Record (MAR) for Resident #26 dated March 2026 revealed the resident received Degludec insulin at bedtime on every day of the month. 2. Review of the medical record for Resident #55 revealed an admission date of 05/04/23 with diagnoses of diabetes mellitus type two and schizoaffective disorder. Review of physician's orders for Resident #55 revealed an order dated 12/17/25 for Novolog insulin per sliding scale four times per day. Review of MAR for Resident #55 dated March 2026 revealed the resident received insulin 87 times during the month. 3. Review of the medical record for Resident #85 revealed an admission date of 08/01/14 with diagnoses of diabetes mellitus type two and paranoid schizophrenia. Review of the physician's orders for Resident #85 revealed an order dated 04/10/25 for Lispro insulin five units at meals. Review of the MAR for Resident #85 dated March 2026 revealed the resident received insulin at meals on every day of the month. 4. Review of the medical record for Resident #86 revealed an admission date of 08/01/24 with diagnoses of diabetes mellitus type two and schizoaffective disorder. Review of the physician's orders for Resident #86 revealed an order dated 02/17/26 for Novolog insulin per sliding scale four times per day and an order for Glargine insulin 25 units every 12 hours. Review of the MAR for Resident #86 dated March 2026 revealed the resident received Novolog insulin per sliding scale 114 times during the month and Glargine insulin 31 times during the month. 5. Review of the medical record for Resident #99 revealed an admission date of 02/02/26 with diagnoses of diabetes mellitus type two and hypertension. Review of the physician's orders for Resident #99 revealed an order dated 02/03/26 for insulin Aspart seven units with meals and insulin Glargine 32 units at bedtime. Review of the MAR for Resident #99 dated March 2026 revealed the resident received insulin Aspart 93 time during the month and insulin Glargine insulin 31 times during the month. Observation on 04/01/26 at 8:42 A.M. of the 100-nursing unit medication cart with Licensed Practical Nurse #225 revealed Resident #26's Degludac insulin was opened on 02/04/26. Resident #55's Novolog insulin was opened on 02/25/26. Resident #85's Lispro insulin was not dated. Resident #86's Novolog and Lantus insulins were both opened on 02/20/26. Resident #99's Aspart and Glargine insulins were not dated. Interview on 04/01/26 at 8:44 A.M. with LPN #225 verified all insulin products were to be dated when removed from the refrigerator and placed in the medication cart, and that insulins have an expiration date of 28 to 30 days from the date placed on the medication cart. LPN #225 confirmed the insulins for Residents #26, #55, #85, #86, and #99 were either expired or not properly dated and should have been discarded. Interview on 04/01/26 at 8:52 A.M. with the Director of Nursing (DON) verified all insulin products were to be dated when removed from refrigerated storage and placed in the medication cart, and that insulins had an expiration date of 28 to 30 days from the date placed on the medication cart. Review of the Insulin Stability Chart provided by the facility's pharmacy revealed Degludec insulin expired 56 days after opening, Novolog (Aspart) insulin expired 28 days after opening, Lispro (Humalog) insulin 28 days after opening, and Lantus (Glargine) insulin 28 days after opening. Review of the facility policy titled Storage of Medications dated 2018 revealed medications should be stored according to the recommendations of the manufacturer or the supplier. The nurse shall place a date opened sticker on the medication and enter the date opened and date of expiration. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No expired medication should be administered to a resident. All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on medical record review, observation, staff interview, and resident interview, the facility failed to provide residents with a dignified dining experience. This affected three (Residents #21, #51 and #54) but had the potential to all affect the 99 facility-identified residents who received meals from the kitchen. The facility census was 101 residents. Findings include:1. Review of the medical record for Resident #21 revealed an admission date of 02/25/25 with diagnoses including end-stage renal disease (ESRD) hypertension, and chronic obstructive pulmonary disease. Review of the Minimum Data Set (MDS) assessment for Resident #21 dated 03/04/26 revealed the resident had moderate cognitive impairment and required set up assistance for eating. 2. Review of the medical record for Resident #51 revealed an admission date of 05/16/24 with diagnoses including dementia and major depressive disorder. Review of the MDS assessment for Resident #51 dated 02/09/26 revealed the resident had moderate cognitive impairment and required supervision for eating. 3. Review of the medical record for Resident #54 revealed an admission date of 11/30/19 with diagnoses including hypertensive heart disease with heart failure, bipolar disorder, and diabetes mellitus type two. Review of the MDS assessment for Resident #54 dated 01/06/26 revealed the resident had moderate cognitive impairment and required supervision for eating. Observation on 03/31/26 at 9:25 A.M. of the nursing 100 Unit dining room revealed Certified Nursing Assistant (CNA) # 267 delivered meal trays to residents which had plastic cutlery. Interview on 03/31/26 at 9:29 A.M. with CNA #267 confirmed the facility frequently provided plastic cutlery with resident meals when either the dishwasher wasn't working or there were not enough metal utensils available for all the residents. Interviews on 03/31/26 between 9:30 A.M. and 9:37 A.M. with Residents #21, #51 and #54 who were all provided with plastic cutlery with their breakfast tray confirmed the residents preferred to use metal utensils with their meals. Resident #54 stated it was difficult to cut through some foods with a plastic knife. Interview on 03/31/26 at 9:41 A.M. with Dietary Supervisor (DS) #292 verified plastic utensils were utilized because the facility did not have an adequate supply of metal utensils.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on medical record review, observation, and staff interview, the facility failed to ensure call lights were kept within resident reach. This affected one (Resident #94) of three residents reviewed for call lights. The facility census was 101 residents. Findings include:Review of the medical record for Resident #94 revealed an admission date of 09/09/24 with diagnoses including disorganized schizophrenia, depression, and anxiety. Review of the Minimum Data Set (MDS) assessment for Resident #94 dated 03/05/26 revealed the resident had severe cognitive impairment and required set-up assistance with oral hygiene, supervision for toileting, bathing, dressing and personal hygiene, and was independent for eating, bed mobility and transfers. Observation on 03/30/26 at 11:09 A.M. of Resident #94 revealed the resident was lying in bed and the call light cord was lying on the floor out of the resident's reach. The call light cord was too short to reach from the wall to the resident's bed. Interview on 03/30/36 at 11:10 A.M. with Certified Nursing Assistant (CNA) #344 verified Resident #94 did not have access to the call light cord because the call light cord was not long enough to reach the resident's bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366220	A. Building B. Wing	04/14/2026

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on medical record review, observation, and staff interview, the facility failed ensure resident rooms were clean and sanitary. This affected one (Resident #94) of three residents reviewed for physical environment. The facility census was 101 residents.Findings include: Review of the medical record for Resident #94 revealed an admission date of 09/09/24 with diagnoses including disorganized schizophrenia, depression, and anxiety. Review of the Minimum Data Set (MDS) assessment for Resident #94 dated 03/05/26 revealed the resident had severe cognitive impairment and required set-up assistance with oral hygiene, supervision for toileting, bathing, dressing and personal hygiene, and was independent for eating, bed mobility and transfers. Observation on 03/30/26 at 11:09 A.M. of Resident #94's room revealed there were spiderwebs above the entire width of the resident's sliding glass door which was approximately six feet wide. Interview on 03/30/36 at 11:10 A.M. with Certified Nursing Assistant (CNA) #344 verified there were spiderwebs above Resident #94's sliding glass door. This deficiency represents noncompliance investigated under Complaint Number 2563479 and Complaint Number 1348234.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366220	A. Building B. Wing	04/14/2026

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on medical record review, observation, resident interview, staff interview, and review of the facility policy, the facility failed to provide nail care for dependent residents. This affected two (Residents #21 and #82) of three residents reviewed for activities of daily living (ADL) care. The facility census was 101 residents. Findings include: 1. Review of the medical record for Resident #21 revealed an admission date of 02/25/25 with diagnoses including end-stage renal disease (ESRD) hypertension, and chronic obstructive pulmonary disease. Review of the Minimum Data Set (MDS) assessment for Resident #21 dated 03/04/26 revealed the resident had moderate cognitive impairment and required staff assistance with ADLs. Review of the care plan for Resident #21 dated 02/25/25 revealed the resident had an ADL deficit. Interventions included staff were to assist the resident with personal hygiene. Observation on 03/31/26 at 9:27 A.M. revealed Resident #21's fingernails were long and jagged with an unknown brown substance underneath the nails. Interview on 03/31/26 with Resident #21 confirmed he would like his fingernails to be cut and cleaned. Interview on 03/31/26 at 9:27 A.M. with Certified Nursing Assistant (CNA) #344 verified Resident #21's fingernails needed nailcare. 2. Review of the medical record for Resident #82 revealed an admission date of 11/13/16 with diagnoses including paranoid schizophrenia, bipolar disorder, hypertension and chronic obstructive pulmonary disease. Review of the MDS assessment for Resident #82 dated 03/19/26 revealed the resident had moderate cognitive impairment and required staff assistance with ADLs. Review of the care plan for Resident #82 dated 07/22/16 revealed the resident had an ADL deficit. Interventions included staff were to assist the resident with personal hygiene. Observation on 03/30/26 at 10:54 A.M. revealed Resident #82's fingernails were long and jagged with an unknown brown substance underneath the nails. Interview on 03/30/26 at 10:54 A.M. with Resident #82 confirmed he would like his fingernails to be cut and cleaned. Interview on 03/31/26 at 9:27 A.M. with CNA #267 verified Resident #82's fingernails needed nailcare. Review of the facility policy titled Personal Care Needs dated 2024 revealed the facility promoted a healthy environment and prevented infection by meeting the personal care needs of the residents. Personal care and ADL support would be provided according to the resident plan of care. Personal care and support included nail care. This deficiency represents noncompliance investigated under Complaint Number 2706077.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, staff interview, and review of the facility policy, the facility failed to ensure staff practiced proper hand hygiene while delivering meal trays to residents. This affected three (Residents #21, #51, #54) and had the potential to affect the 99 facility-identified residents who received meals prepared in the facility kitchen. The facility census was 101 residents. Findings include: Observation on 03/31/26 from 9:31 A.M. to 9:38 A.M. revealed Certified Nursing Assistant (CNA) #267 delivered breakfast meal trays in the 100-nursing unit dining room to Residents #21, #51 and #54 and failed to sanitize hands before and after passing the meal trays to the residents. CNA #267 opened Resident #21's milk carton and did not sanitize her hands before and after assisting the resident. Interview on 03/31/26 at 9:38 A.M. with CNA #267 verified she should have sanitized her hands before and after passing a meal tray to each resident. Interview on 04/03/26 at 11:25 A.M. with Infection Control Preventionist #310 verified staff are to sanitize hands before and after delivering a resident meal tray. Review of the facility policy titled Hand Hygiene dated February 2026 revealed the facility considered hand hygiene the primary means to prevent the spread of infection. Staff should practice hand hygiene before and after assisting a resident with meals or passing trays to another resident.