STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366236	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Shepherd Village	422 North Burnett Road Springfield, OH 45503

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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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. Based on medical record review, facility list review, resident interview, staff interviews, and policy review, the facility failed to ensure residents' personal funds were available in a timely manner. This had the potential to affect 22 Residents (#2, #3, #4, #7, #11, #12, #13, #20, #22, #23, #24, #26, #37, #43, #46, #48, #52, #53, #54, #56, #266, #367) of 22 identified to have personal fund accounts with the facility. The facility census was 65. Findings include: Review of facility generated list of personal funds account revealed 22 Residents (#2, #3, #4, #7, #11, #12, #13, #20, #22, #23, #24, #26, #37, #43, #46, #48, #52, #53, #54, #56, #266, #367) identified to have personal fund accounts with the facility. Review of Resident #7's medical record revealed an admission date of 12/30/22. Diagnoses include anxiety, schizophrenia, hypothyroidism, major depressive disorder, Alzheimer's, heart failure, and kidney disease. Interview on 04/29/25 at 8:11 A.M., revealed a concern related to Resident #7 being able to access his personal funds. Resident #7 shared that he is unable to withdrawal money on the weekend and has to wait until Monday. Interview on 04/30/25 at 3:10 P.M., with Business Office Manager #228 revealed the activities staff will ask residents once a week if they would like to withdrawal funds. Funds are only available to residents Monday through Friday and no one is in the facility to handle funds on the weekend. Interview on 05/01/25 at 10:25 A.M., with Certified Nurse Aide #279 revealed on the weekends no one has access to resident funds. Residents are required to wait until Monday when a manager is in the facility to withdrawal their funds. Review of the undated policy titled, Resident Funds Policy and Procedure revealed a resident request for access to their funds will be honored the same for amounts less than $100 or amounts less than $50 for Medicaid residents.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0576 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on resident interview, staff interview and policy review, the facility failed to ensure residents received mail on the weekends. This had the potential to affect all 65 residents residing in the facility. The facility census was 65. Findings include: Interview on 04/29/25 at 11:24 A.M., during resident group meeting, with Resident #1, #6, and #8, verified the mail was not delivered on Saturday, only Monday through Friday. Interview on 04/30/25 at 1:00 P.M., with Business Office Manager (BOM) #228 reported she would sort the mail Monday through Friday, and then activities would pass mail to the residents. BOM #228 verified the mail was not given to residents on Saturday, only Monday through Friday. Review of the policy titled, Resident Rights Policy and Procedure, dated 2025, revealed each resident had the right to send and receive mail, and to receive letters, packages, and other materials delivered to the facility for the resident through a means other than a postal service and should comply with the state and federal law.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure psychotropic medications were ordered for an approved diagnosis. This affected one (#9) of five residents reviewed for unnecessary medication. The facility census was 65. Findings include: Review of the medical record for Resident #9 revealed an admission date of 03/08/25. Diagnoses included abdominal pain, spinal stenosis, gastritis and malnutrition. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9 had moderate cognitive impairment with a Brief Interview Mental Status (BIMS) of 9. Review of active physician orders dated 03/08/25 revealed an order for Aripiprazole oral tab 5 milligrams (mg) once daily in morning (scheduled at 8:00 A.M.) was ordered for Hypotension. This medication is a antipsychotic. Interview on 05/01/25 at 8:42 A.M., with Regional Nurse #500 and Regional Nurse #508 confirmed Aripprazole (Abilify) was not used to treat hypotension and confirmed the order did not contain an approved diagnosis. Also acknowledged Resident #9 had a pharmacy review and revealed this should have been caught. Interview on 05/01/25 at 9:00 A.M., with Director of Nursing revealed the hospital documentation had a diagnosis of mood disorder and confirmed the facility did not have that diagnosis listed in the electronic medical record. Review of the undated policy titled, Pharmacy Services revealed the facility shall ensure the medication was documented to treat a specific condition that was documented in the medical record.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff and resident family interview, observation, and policy review, the facility failed to implement the abuse policy for reporting and investigating an alleged injury of unknown origin. This affected one (#55) of three residents reviewed for abuse. The census was 65. Findings included: Medical record review for Resident #55 revealed an admission date of 02/25/25. Her medical diagnoses was multiple sclerosis (MS) and non-Alzheimer's dementia. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #55 was rarely or never understood. Her functional status was substantial/maximal assistance for eating, dependent for toileting, bed mobility, and transfers were not attempted due to safety concerns. She used a Hoyer lift. Review of the progress note dated 04/27/25 at 2:47 P.M., documented by Licensed Practical Nurse (LPN) #249, revealed the family approached the nurse regarding a discoloration to resident's left leg. There was bruising seen. The family stated she gets her leg caught on the Hoyer lift at times. The physician was notified and a new order to watch for symptoms was initiated. Interview on 04/28/25 at 12:06 P.M., with Resident #55's Family Member, reported Resident #55 had a dark red bruise that wrapped around the lower left leg from the inside ankle to the calf and the ankle was swollen. He stated it looked like hand prints to him. Review of the progress notes written on 04/28/25 at 2:57 P.M., by the Director of Nursing (DON), revealed she assessed the bruised area on Resident #55's area and the bruise lined up with the wheelchair and resident crossing legs on the pedals. New intervention was to place a pillow on the foot pedals to prevent further bruising. The area measured 6 centimeters (cm) by 5 cm by 0.1 cm and the husband was made aware. Interview on 04/29/25 at 2:00 P.M., with the DON revealed she didn't think she needed to file an injury of unknown origin even though the resident was not able to tell her how the injury happened. The DON reported she assessed the bruise but didn't have any documenting to support she did a couple of interviews with anyone. She confirmed she didn't follow the abuse policy. Interview on 04/29/25 at 2:12 P.M., with LPN #249, revealed the family of Resident #55 asked her to take a look at a bruise on the resident's left leg. LPN #249 stated Certified Nursing Aides (CNA) #225 and #278 saw the area on 04/26/25 and it was reddened. LPN #249 reported when she looked at the area it had some purple and light tent of red to the inside of the left ankle and up the back of the shin. The family stated he thought it was the Hoyer lift because at times she will get her left leg caught in the lift if the staff doesn't' move her left foot out of the way. She reported it made more sense it would be the Hoyer lift instead of the resident resting her crossed legs on the pads of the wheelchair. LPN #249 reported if the bruise would have been on the outside of the ankle then it could have been from the wheelchair. LPN #249 stated she called the two CNAs (#225 and #278) and asked them if they hurt the resident while transferring her in the Hoyer lift but they both denied it. She reported the bruise to the DON. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/29/25 at 2:20 P.M., of Resident #55 with the LPN #249, revealed the resident was sitting in her wheelchair. She didn't have her legs crossed and her legs were dangling and she didn't have a pillow to protect her legs from the wheelchair in place. The light bruising was on the inside of her left ankle and ran up the calf to about 6 cm long. The resident wasn't able to answer any questions about the bruise. When the nurse placed a pillow under her legs in the wheelchair the resident wasn't able to follow commands about raising her legs and the nurse had to place the legs onto the pads of the wheelchair. Interview on 04/29/25 at 2:30 P.M., with LPN #249 revealed she didn't know about the new intervention for the pillow to placed under the resident's legs to protect her from the wheelchair. Interview on 04/29/25 at 4:23 P.M., with CNA #225 revealed she saw the redness on the resident's leg on 04/26/25 and reported it to the nurse and they both assumed it happened in the wheelchair or in therapy. Review of the undated policy titled Resident's Rights to Freedom from Abuse, Neglect and Exploitation Policy and Procedure revealed to ensure a thorough investigation was conducted for the alleged violation. The policy further revealed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported in the proper time frame pursuant to this policy.

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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 medical record review, staff and resident family interview, observation, and policy review, the facility failed to report an alleged injury of unknown origin. This affected one (#55) of three residents reviewed for abuse. The census was 65. Findings included: Medical record review for Resident #55 revealed an admission date of 02/25/25. Her medical diagnoses was multiple sclerosis (MS) and non-Alzheimer's dementia. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #55 was rarely or never understood. Her functional status was substantial/maximal assistance for eating, dependent for toileting, bed mobility, and transfers were not attempted due to safety concerns. She used a Hoyer lift. Review of the progress note dated 04/27/25 at 2:47 P.M., documented by Licensed Practical Nurse (LPN) #249, revealed the family approached the nurse regarding a discoloration to resident's left leg. There was bruising seen. The family stated she gets her leg caught on the Hoyer lift at times. The physician was notified and a new order to watch for symptoms was initiated. Interview on 04/28/25 at 12:06 P.M., with Resident #55's Family Member, reported Resident #55 had a dark red bruise that wrapped around the lower left leg from the inside ankle to the calf and the ankle was swollen. He stated it looked like hand prints to him. Review of the progress notes written on 04/28/25 at 2:57 P.M., by the Director of Nursing (DON), revealed she assessed the bruised area on Resident #55's area and the bruise lined up with the wheelchair and resident crossing legs on the pedals. New intervention was to place a pillow on the foot pedals to prevent further bruising. The area measured 6 centimeters (cm) by 5 cm by 0.1 cm and the husband was made aware. Interview on 04/29/25 at 2:00 P.M., with the DON revealed she didn't think she needed to file an injury of unknown origin even though the resident was not able to tell her how the injury happened. The DON reported she assessed the bruise but didn't have any documenting to support she did a couple of interviews with anyone. She confirmed she didn't follow the abuse policy. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/29/25 at 2:12 P.M., with LPN #249, revealed the family of Resident #55 asked her to take a look at a bruise on the resident's left leg. LPN #249 stated Certified Nursing Aides (CNA) #225 and #278 saw the area on 04/26/25 and it was reddened. LPN #249 reported when she looked at the area it had some purple and light tent of red to the inside of the left ankle and up the back of the shin. The family stated he thought it was the Hoyer lift because at times she will get her left leg caught in the lift if the staff doesn't' move her left foot out of the way. She reported it made more sense it would be the Hoyer lift instead of the resident resting her crossed legs on the pads of the wheelchair. LPN #249 reported if the bruise would have been on the outside of the ankle then it could have been from the wheelchair. LPN #249 stated she called the two CNAs (#225 and #278) and asked them if they hurt the resident while transferring her in the Hoyer lift but they both denied it. She reported the bruise to the DON. Observation on 04/29/25 at 2:20 P.M., of Resident #55 with the LPN #249, revealed the resident was sitting in her wheelchair. She didn't have her legs crossed and her legs were dangling and she didn't have a pillow to protect her legs from the wheelchair in place. The light bruising was on the inside of her left ankle and ran up the calf to about 6 cm long. The resident wasn't able to answer any questions about the bruise. When the nurse placed a pillow under her legs in the wheelchair the resident wasn't able to follow commands about raising her legs and the nurse had to place the legs onto the pads of the wheelchair. Interview on 04/29/25 at 2:30 P.M., with LPN #249 revealed she didn't know about the new intervention for the pillow to placed under the resident's legs to protect her from the wheelchair. Interview on 04/29/25 at 4:23 P.M., with CNA #225 revealed she saw the redness on the resident's leg on 04/26/25 and reported it to the nurse and they both assumed it happened in the wheelchair or in therapy. Review of the undated policy titled Resident's Rights to Freedom from Abuse, Neglect and Exploitation Policy and Procedure revealed to ensure a thorough investigation was conducted for the alleged violation. The policy further revealed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported in the proper time frame pursuant to this policy.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff and resident family interview, observation, and policy review, the facility failed to thoroughly investigate an alleged injury of unknown origin. This affected one (#55) of three residents reviewed for abuse. The census was 65. Findings included: Medical record review for Resident #55 revealed an admission date of 02/25/25. Her medical diagnoses was multiple sclerosis (MS) and non-Alzheimer's dementia. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #55 was rarely or never understood. Her functional status was substantial/maximal assistance for eating, dependent for toileting, bed mobility, and transfers were not attempted due to safety concerns. She used a Hoyer lift. Review of the progress note dated 04/27/25 at 2:47 P.M., documented by Licensed Practical Nurse (LPN) #249, revealed the family approached the nurse regarding a discoloration to resident's left leg. There was bruising seen. The family stated she gets her leg caught on the Hoyer lift at times. The physician was notified and a new order to watch for symptoms was initiated. Interview on 04/28/25 at 12:06 P.M., with Resident #55's Family Member, reported Resident #55 had a dark red bruise that wrapped around the lower left leg from the inside ankle to the calf and the ankle was swollen. He stated it looked like hand prints to him. Review of the progress notes written on 04/28/25 at 2:57 P.M., by the Director of Nursing (DON), revealed she assessed the bruised area on Resident #55's area and the bruise lined up with the wheelchair and resident crossing legs on the pedals. New intervention was to place a pillow on the foot pedals to prevent further bruising. The area measured 6 centimeters (cm) by 5 cm by 0.1 cm and the husband was made aware. Interview on 04/29/25 at 2:00 P.M., with the DON revealed she didn't think she needed to file an injury of unknown origin even though the resident was not able to tell her how the injury happened. The DON reported she assessed the bruise but didn't have any documenting to support she did a couple of interviews with anyone. She confirmed she didn't follow the abuse policy. Interview on 04/29/25 at 2:12 P.M., with LPN #249, revealed the family of Resident #55 asked her to take a look at a bruise on the resident's left leg. LPN #249 stated Certified Nursing Aides (CNA) #225 and #278 saw the area on 04/26/25 and it was reddened. LPN #249 reported when she looked at the area it had some purple and light tent of red to the inside of the left ankle and up the back of the shin. The family stated he thought it was the Hoyer lift because at times she will get her left leg caught in the lift if the staff doesn't' move her left foot out of the way. She reported it made more sense it would be the Hoyer lift instead of the resident resting her crossed legs on the pads of the wheelchair. LPN #249 reported if the bruise would have been on the outside of the ankle then it could have been from the wheelchair. LPN #249 stated she called the two CNAs (#225 and #278) and asked them if they hurt the resident while transferring her in the Hoyer lift but they both denied it. She reported the bruise to the DON. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/29/25 at 2:20 P.M., of Resident #55 with the LPN #249, revealed the resident was sitting in her wheelchair. She didn't have her legs crossed and her legs were dangling and she didn't have a pillow to protect her legs from the wheelchair in place. The light bruising was on the inside of her left ankle and ran up the calf to about 6 cm long. The resident wasn't able to answer any questions about the bruise. When the nurse placed a pillow under her legs in the wheelchair the resident wasn't able to follow commands about raising her legs and the nurse had to place the legs onto the pads of the wheelchair. Interview on 04/29/25 at 2:30 P.M., with LPN #249 revealed she didn't know about the new intervention for the pillow to placed under the resident's legs to protect her from the wheelchair. Interview on 04/29/25 at 4:23 P.M., with CNA #225 revealed she saw the redness on the resident's leg on 04/26/25 and reported it to the nurse and they both assumed it happened in the wheelchair or in therapy. Review of the undated policy titled Resident's Rights to Freedom from Abuse, Neglect and Exploitation Policy and Procedure revealed all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, ensure a thorough investigation is conducted for the alleged violation.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical records and staff interviews, the facility failed to develop care plans to meet the needs of the residents. This affected four (#30, #36, #266, and #366) of 24 residents reviewed for care plans. The facility census was 65. Findings include: 1. Review of the medical record for Resident #36 revealed an admission date of 08/25/23. Diagnoses included dementia, major depressive disorder, and anxiety disorder. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #36 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of three. This resident was assessed to require setup with eating, supervision with toileting, bathing, dressing, and transfers. Review of the physician order dated 03/12/25 revealed Resident #36 was ordered Ativan 0.5 milligrams (mg), give one tablet by mouth two times a day for anxiety. Review of the care plan for Resident #36 revealed she did not have a care plan for psychotropic medications relating to anxiety medication. Interview on 05/01/25 at 11:00 A.M., with MDS Nurse #501 verified Resident #36 did not have a care plan created for anxiety medications. 2. Review of the medical record for Resident #266 revealed an admission date of 01/06/23. Diagnoses included Alzheimer's disease, Parkinson's disease, anxiety disorder, and type two diabetes mellitus (DM II). Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #266 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of nine. This resident was assessed to require independent with eating, partial assistance with toileting and transfers, dependent with bathing, and substantial assistance with dressing. Review of the physician order dated 03/17/25 revealed Resident #266 was ordered catheter care every shift. Interview on 04/30/25 at 2:51 P.M., with MDS Nurse #501 verified Resident #366 did not have a care plan created for the use of urinary catheter. 3. Review of the medical record for Resident #366 revealed an admission date of 02/19/25 with a discharge date of 03/28/25. Diagnoses included cellulitis, chronic kidney disease stage three, type two diabetes mellitus (DM II), and unstageable pressure ulcer of right heel. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #366 had intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 13. This resident was assessed to require setup with eating, dependent with toileting, and substantial assistance with bathing, dressing, and transfers. Review of section M of the admission MDS dated [DATE] revealed Resident #366 had eight venous and arterial ulcers present. Review of the care plan for Resident #366 revealed she had no care plan for impaired skin integrity. Interview on 04/30/25 at 2:51 P.M., with MDS Nurse #501 verified Resident #366 did not have a care plan created for skin impairment. 4. Review of Resident #30's medical record revealed an admission date on 08/13/24. Diagnoses included chronic obstructive pulmonary disease (COPD), congestive heart failure, hypertension, hemiplegia, hyperlipidema, and protein-calorie malnutrition. Review of the MDS assessment dated [DATE] revealed the Resident #30 was cognitively intact. Review of Resident #30's medical record revealed the resident was accepted by hospice on 01/15/25 for diagnosis of COPD. Review of Resident #30's care plan on 05/01/25 found no evidence of the resident being on hospice included in the care plan. Interview on 05/01/25 at 11:13 A.M., with the Director of Nursing verified Resident #30 did not have a care plan in place for hospice service.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interviews, family interviews, staff interviews, and policy review, the facility failed to ensure care conferences were completed quarterly and the interdisciplinary team was present for five (#7, #13, #16, #26, and #55) of five residents reviewed for care conferences. The facility also failed to ensure revisions of care plans were updated for six (#7, #18, #30, #33, #51 and #62) of 24 care plans reviewed during the annual survey. The facility census was 65. Findings included: 1. Medical record review for Resident #7 revealed an admission date of 12/30/22. His medical diagnoses included arteriosclerotic heart disease, schizophrenia, Alzheimer's, diabetes, chronic kidney disease, and convulsions. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #7 was severely cognitively impaired. His functional status was setup or clean-up assistance for eating, substantial/maximal assistance for toileting, supervision or touching assistance for bed mobility and transfers. He was always incontinent for bladder and codes for a colostomy. He was coded for wandering. a. Review of the care conferences since 01/02/24 revealed Resident #7 had one meeting on 01/02/24. There wasn't any notes on the care conference paperwork. The paperwork said to look at the progress note for 01/02/24 but there was no progress notes for this day regarding the care conference. Interview on 04/29/25 at 8:13 A.M., with Resident #7's Family Member revealed they were having care conference quarterly and then they stopped. Interview on 04/30/25 at 2:17 P.M., with the Social Worker Designee (SWD) #263 confirmed there had only been one care conference for Resident #7 on 01/02/24. b. Review of the care plan dated 01/23/24 revealed Resident #7 was at risk for elopement. Intervention initiated on 09/18/24 revealed 15-minute checks. Review of the 15-minute checks forms revealed they were discontinued on 09/19/24. Interview on 04/30/25 at 8:54 A.M., with MDS Nurse #501 confirmed the care plan should have been updated to reflect the resident was no longer on 15-minute checks. 2. Medical record review for Resident #55 revealed an admission date of 02/25/25. Her medical diagnoses was Multiple Sclerosis (MS) and non-Alzheimer's dementia. Review of the admission MDS dated [DATE] revealed Resident #55 was rarely or never understood. Her functional status was substantial/maximal assistance for eating, dependent for toileting, bed mobility, and transfers were not attempted due to safety concerns. She used a Hoyer lift. Review of care conferences for Resident #55 since 02/25/25 revealed one on 03/25/25 and there was one signature on the form. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/28/25 at 12:15 P.M., revealed Resident #55's Family Member stated they did not have a care conference upon admission and not until a month after admission. Interview on 04/30/25 at 2:17 P.M., with the Social Worker Designee (SWD) #263 confirmed there was not a care conference upon admission and there was not members of the disciplinary team present for the meeting for Resident #55. 9. Review of medical record for Resident #62 revealed admission date of 9/13/24. The resident was currently receiving hospice services and had been admitted with diagnoses including alcohol dependence with alcohol induced persisting dementia, anxiety, unspecified dementia with unspecified severity with agitation. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he severely impaired cognition. He was dependent on all Activities of Daily Living. No falls were documented in look back. Review of the care plan a risk for falls related to gait and balance problems, poor communication and unawareness of safety needs. Interventions included to use mechanical lift to move to a safe location to prevent falls. Interview on 04/28/25 at 9:37 A.M., with Certified Nursing Assistant (CNA) #242 revealed she was scheduled for one-on-one care for Resident #62 due to his wanderings and falls. Interview on 04/30/25 at 10:38 A.M., with MDS Nurse #501 acknowledged Resident #62's care plan had not been updated to reflect he no longer required a mechanical lift, he required one to one supervision for safety and did not contain an updated hospice care plan. 3. Review of the medical record for Resident #13 revealed an admission date of 10/25/22. Diagnoses included cerebral infarction, diabetes mellitus, hemiplegia and hemiparesis affecting right dominant side, and chronic obstructive pulmonary disease (COPD). Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 10. This resident was assessed to require setup with eating, substantial assistance with toileting, bathing, and transfers, and dependent with dressing. Review of the care conferences for the last 12 months for Resident #13 revealed attempted meetings on 06/04/24, 02/14/25, and 03/10/25 because Resident #13's daughter did not show. Interview on 04/30/25 at 9:00 A.M., with SWD #263 verified care conferences were to be completed quarterly. SWD #263 verified Resident #13 did not have care conferences completed quarterly as required. 4. Review of the medical record for Resident #26 revealed an admission date of 08/26/24. Diagnoses included major depressive disorder, schizoaffective disorder, and generalized anxiety disorder (GAD). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #26 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of zero. This resident was assessed to require setup with eating, partial assistance with toileting, bathing, supervision with dressing and transfers. Review of the care conferences for the last 12 months for Resident #26 revealed a care conference was completed on 03/12/24 and 06/25/24. Interview on 04/30/25 at 9:00 A.M., with SWD #263 verified care conferences were to be completed quarterly. SWD #263 verified Resident #26 did not have care conferences completed quarterly as required. 10. Review of the medical record for Resident #33 revealed an admission date of 09/19/24. Medical diagnoses included sepsis and diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #33 was cognitively impaired. Her functional status was dependent for eating, oral hygiene, toileting, bathing, dressing, and positioning in bed. Review of Resident #33 medical records revealed she was hospitalized [DATE] through 02/03/25. Review of wound documentation notes dated 02/07/25 revealed Resident #33 had the following skin impairments an unstageable wound on her right gluteal fold, an unstageable wound on her right buttock, Stage 4 pressure ulcer on her sacrum and left ischium, a Stage 3 pressure ulcer to her left posterior thigh and left buttocks, and a deep pressure injury (DTI) to her right heel. Review of the care plan dated 10/22/24, revised 01/14/25, for Resident #33 revealed the resident had a stage 3 pressure ulcer on her left buttock, a stage 4 pressure ulcer on her left ischium, a stage 4 pressure ulcer on her sacrum, and a DTI on her right heel. Care plan for Resident #33 revealed interventions included to administer treatments as ordered and monitor for effectiveness. Air mattress to bed at all times due to wounds. Educate staff to ensure heel/moon boots were on and heels were floated. Follow facility policies and protocols for the prevention and treatment of skin breakdown. Monitor dressing to ensure it is intact and adhering, report lose dressing to treatment nurse. Review of care plan for Resident #33 revealed there was no documentation or interventions in place for Resident #33 wound on her left posterior thigh, right buttock, or right gluteal fold. Interview on 04/30/25 at 8:54 A.M., with MDS nurse #501 confirmed the care plan was not updated to include the current skin impairments. Review of the undated policy titled Comprehensive Person-Centered Care Planning Policy and Procedure revealed the care plans would be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Collaboration will be an emphasis on partnering between residents and/or his or her representative, and all staff and disciplines involved in the resident's care in developing the plan of care. There is recognition that healing (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	happens in relationships and in the meaningful sharing of power and decision-making. Empowerment, voice, and choice - Ensuring that the resident's choice and preferences are honored and that residents are empowered to be active participants in their care and decision-making, including recognition of, and building on each resident's strengths. Comprehensive Care Plans. 1. The Facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth under the law that includes measurable objectives and timeframe's to meet each resident's medical, nursing, and mental and psychological needs that are identified in the comprehensive assessment. 2. The comprehensive care plan will describe the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychological well-being as required under law; and b. Any services that would otherwise be required under law or regulation but are not provided due to the resident's exercise of rights, including the resident's right to refuse treatment. 3. The comprehensive care plan shall be: a. Developed within 7 days after completion of the comprehensive assessment. Interview with MDS Nurse #501 on 05/01/25 at 10:15 A.M. verified that if there are new skin issues she should be updated, and the care plan should be updated at that time. 5. Review of Resident #16's medical record revealed an admission date of 02/07/25. Diagnoses included coronary artery disease, hypertension, diabetes mellitus, hyperlipidemia, thyroid disorder, seizure disorder, anxiety, and depression. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed resident #16 was cognitively intact. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care conference dated 02/20/25 revealed that attendees for the conference were Licensed Practical Nurse #213 and a family member of Resident #16. The care conference was coordinated by the SWD #263. Further review of the care conference form revealed that no comments of what was discussed during the conference were include on the form. Interview on 04/30/25 at 2:13 P.M., with the SWD #263 verified the comment section of the care conference form was blank. 6. Review of Resident #51's medical record revealed an admission date of 02/07/25. Diagnoses include congestive heart failure, hypertension, diabetes mellitus, and hyperlipidemia. Review of the MDS assessment dated [DATE] revealed resident #51 was cognitively intact. Further review of Resident #51's medical record revealed Resident #51 has an active order from 02/10/25 requiring blood sugar checks to be completed before each meal and at bed time. The order includes the physician must be contacted if blood sugar levels are less than 70 or more than 250. Review of the care plan for Resident #51 on 04/30/25 revealed the blood sugar checks and contacting the physician if levels were below 70 or above 250 were not included in the care plan. Interview on 04/30/25 at 10:42 A.M., with MDS Nurse #501 confirmed that blood sugar checks should be added to a care plan for a resident with orders to monitor blood sugar levels. 7. Review of Resident #18's medical record revealed an admission date of 05/07/24. Diagnoses include anemia, hypertension, hyperlipidemia, Alzheimer's, dementia, and depression. Review of the MDS assessment dated [DATE] revealed resident #18 is cognitively impaired. Review of Resident #18's progress note date 10/08/24 revealed a house nutritional supplement of 237 milliliters (ml) once a day was ordered. Review of Resident #18's progress note dated 01/10/25 revealed weekly weights were ordered. Review of Resident #18's nutritional assessment dated [DATE] revealed a recommendation to initiate weekly weights and increase the house nutritional supplement to 237 ml twice a day. Review of Resident 18's care plan on 04/30/25 revealed weekly weights and nutritional supplements were not added to the nutrition care plan. Interview on 04/30/25 at approximately 5:00 P.M., with the Director of Nursing (DON) verified Resident #18's care plan was not revised with the order for weekly weights or interventions. 8. Review of Resident #30's medical record revealed Resident #30 was admitted to the facility on [DATE]. Diagnoses included acute and chronic respiratory failure, chronic pulmonary disease, peripheral vascular disease, hypertension, hemiplegia, hyperlipidemia, and protein-calorie malnutrition. Review of Resident #30's MDS assessment dated [DATE] revealed the resident was cognitively intact. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Residents #30's medical record on 05/01/25 revealed that Resident #30 had an advanced directive for DNR Comfort Care dated 01/18/25. Review of Resident #30's care plan on 05/01/25 revealed that Resident #30's advance directive was listed for a full code. Interview on 05/01/25 at 11:13 A.M., with the DON verified the advanced directive in Resident #30's care plan was not revised after the DNR Comfort Care was signed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff and family interview, and policy review, the facility failed to ensure a resident dependent on staff for assistance with activities of daily living was provided oral hygiene. This affected one (#55) of five residents reviewed for Activities of Daily Living (ADL). The facility census was 65. Findings included: Medical record review for Resident #55 revealed an admission date of 02/25/25. Her medical diagnoses was Multiple Sclerosis (MS) and non-Alzheimer's dementia. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #55 was rarely or never understood. Her functional status was substantial/maximal assistance for eating, dependent for toileting, bed mobility, and transfers were not attempted due to safety concerns. She used a Hoyer lift. Review of care plan dated 03/05/25 revealed Resident #55 was at risk for poor oral hygiene. Her intervention was to provide mouth care as per the ADL personal hygiene. Interview on 04/28/25 at 12:16 P.M., with Resident #55's Family Member revealed she wasn't getting her teeth brushed like she should be. He further revealed the resident brushed her teeth after every meal when she lived at home. Observation at the same time as the interview revealed Resident #55's teeth had a yellow film on them. Observation on 04/29/25 at 9:30 A.M. revealed Registered Nurse (RN) #285 was feeding Resident #55's breakfast to her. Interview on 04/29/25 at 4:40 P.M., with RN #285 revealed she didn't brush Resident #55's teeth after breakfast. Interview on 04/30/25 at 3:14 P.M., with Certified Nursing Aide (CNA) #204 revealed she fed the resident breakfast and lunch but didn't brush her teeth after the meals. She reported the teeth brushing was supposed to be after meals. Review of the medical record for the date of 04/30/25 revealed no documentation of the teeth were not brushed after breakfast or lunch for Resident #55. Review of the policy titled, Activities of Daily Living, dated 03/01/18, revealed residents who are unable to carry out ADL's independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. This deficiency represents the noncompliance investigated under Complaint Numbers OH00164520 and OH00164238.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of physician orders, staff interviews, Certified Nursing Practitioner interview, and review of policy, the facility failed to ensure physician orders were clarified when to contact the physician for a resident daily weight change for Resident #41. The facility failed to physician orders were followed to obtain blood sugars and contact the physician when blood sugars were out of the parameters for Resident #51. The facility failed to ensure coordination with hospice services were established for hospice care for Resident #30. The facility failed to ensure skin assessments and treatments were completed for Resident #13. This affected four (#13, #30, #41 and #51) of 24 residents records reviewed for quality of care . The facility census was 65. Findings include: 1. Review of medical record for Resident #41 revealed admission date of 01/09/23, with diagnoses including major depressive disorder, alcohol abuse, chronic viral hepatitis, anxiety and alcohol dependence. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview Mental Status (BIMS) score of 14, indicating intact cognition. He was independent for Activities of Daily Living. Review of the plan of care revealed a care plan for fluid overload or a potential for fluid volume overload related to the diagnosis of Hepatitis C. Interventions included to provide medications as ordered and to monitor, document and report any signs or symptoms of fluid overload. Review of the 04/17/25 physician note revealed Resident #41 had been seen due to pulmonary congestion on a recent chest x-ray with increased dyspnea (feeling short of breath) over a few days. The plan was to give Lasix (diuretic) 40 milligrams (mg) once and then reduce Lasix to 20 mg and daily weights for two weeks. Review of the daily weights from 04/18/25 through 04/28/25 revealed the weight on 04/20/25 was 225.5 pounds, on 04/21/25 was 228 pounds, on 04/26/25 was 226 pounds, and on 04/27/25 was 228 pounds. Interview on 04/30/25 at 9:21 A.M. , with Licensed Practical Nurse (LPN) #213 revealed she was unaware Resident #41 was getting daily weights and thought it may have been ordered by the dietician for nutrition. Interview on 04/30/25 at 9:55 A.M., with the Director of Nursing revealed Resident #41 had been ordered daily weights due to a recent chest X-Ray which had showed chest congestion, she shared he had received Lasix to remove fluid. She acknowledged staff did not clarify when the physician wanted notified for a weight change. Interview on 04/30/25 at 10:38 A.M., with Certified Nurse Practitioner (CNP) #502 revealed Resident #41 had a recent Chest X-ray which revealed Pulmonary congestion, he had ordered Lasix to remove excess fluid and daily weights to monitor fluid changes. He shared it was his expectation the nursing staff would be knowledgeable to know to contact him with a two pound weight gain overnight or five pounds in a week. He verified he had not been informed of the 04/21/25 or 04/27/25 weight gain. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of the medical record for Resident #13 revealed an admission date of 10/25/22. Diagnoses included cerebral infarction, diabetes mellitus, hemiplegia and hemiparesis affecting right dominant side, and chronic obstructive pulmonary disease (COPD). Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 10. This resident was assessed to require setup with eating, substantial assistance with toileting, bathing, and transfers, and dependent with dressing. Review of the care plan dated 06/13/24 revealed Resident #13 had potential impairment to skin integrity related to need for assistance with incontinence and right sided hemiplegia. Interventions included avoid scratching and keep hands from excessive moisture, encourage good nutrition and hydration, keep skin clean and dry, provide treatment to any moisture associated skin damage (MASD) that flared up, and use draw sheet or lifting device to move her. Review of the progress note dated 02/17/25 at 6:49 P.M., revealed Resident #13 had an open lesion to the right gluteal fold that was acquired in-house. No measurements were completed. Review of the progress note dated 02/26/25 at 2:36 A.M., revealed Resident #13 had open lesion to the right gluteal fold. Area had gotten worse. Education provided to change positions every two hours and apply moisture barrier cream. Review of the progress note date 02/27/25 at 5:13 P.M., revealed Resident #13 had a new area to the left iliac crest related to moisture associated skin damage (MASD) that was acquired in-house. Review of the physician order dated 03/01/25 revealed Resident #13 was ordered to cleanse area to right buttock with soap and water. Apply medihoney and border foam dressing daily and as needed every day shift. Review of the medical record revealed Resident #13 was never seen by the wound care team after two new areas developed in-house. Review of the weekly skin assessments dated 04/10/25 and 04/24/25 for Resident #13 revealed the assessment was incomplete. Interview on 05/01/25 at 8:51 A.M. with Assistant Director of Nursing (ADON) verified inconsistencies and completion of weekly skin assessments on Resident #13. ADON stated a referral should have been completed in February when Resident #13 had a new open lesion to the right gluteal fold. Review of the facility policy titled, Wound Care, revised 2010 revealed the purpose of the procedure was to provide guidelines for the care of wounds to promote healing. The follow information should be recorded in the resident's medical record: the type of wound care given, the date and time wound care was given, the position in which the resident was placed, the name and title of the individual performing the wound care, any change in the resident's condition, all assessment data (wound bed color, size, drainage, etc.) obtained when inspecting the wound, how the resident tolerated the procedure, if the resident refused treatment, and the signature of the person recording the data. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This deficiency represents the noncompliance investigated under Complaint Numbers OH00164520 and OH00164238. 2. Review of Resident #51's medical record revealed an admission date of 02/07/25. Diagnoses include congestive heart failure, hypertension, diabetes mellitus, and hyperlipidemia. Review of the MDS assessment dated [DATE] revealed resident #51 was cognitively intact. Further review of Resident #51's active physician order dated 02/10/25 requiring blood sugar checks to be completed before each meal and at bed time. The order includes that the physician must be contacted if blood sugar levels are less than 70 or more than 250. Review of Resident #51's vitals summary sheet for February 2025 revealed missing blood sugar checks on 02/12/25, 02/18/25, 02/19/25, 02/20/25, 02/21/25, 02/22/35, 02/23/25, 02/26/25, 02/27/25, and 02/28/25. Further review revealed that blood sugar levels were not documented for the entire day on 02/21/25 and 02/28/25. Review of Resident #51's vitals summary sheet for March 2025 revealed missing blood sugar checks each day for the entire month of March. Further review revealed that blood sugar levels were not documented for the entire day on 03/04/25, 03/11/25, 03/14/25, 03/18/25, 03/24/25, and 03/28/25. Review of Resident #51's vitals summary for April 2025 revealed missing blood sugar check on days 04/01/25-04/12/25. Further review revealed that blood sugar levels were not documented for the entire day on 04/02/25, 04/03/25, 04/06/25, and 04/08/25. Further review of Resident #51's vitals summary revealed that Resident #51 experienced blood sugar levels more than 250 on 02/11/25 (345), 02/12/25 (456 and 472), 02/15/25 (252, 399 and 386), 02/24/25 (253), 02/26/25 (271), 03/07/25 (456), 03/08/25 (274), 03/09/25 (285), 03/15/25 (360), 03/21/25 (336), 03/22/25 (400), 03/23/25 (256), 03/25/25 (289), 03/26/25 (289 and 255), 03/29/25 (306), 03/30/25 (426), 03/31/25 (350), 04/01/25 (417), 04/04/25 (417 and 302), 04/04/25 (300), 04/11/25 (357 and 254), 04/12/15 (399, 302 and 488), 04/13/25 (298, 311, 301 and 554), 04/14/25 (422, 308, and 301), 04/15/25 (278, 310, and 422), 04/18/25 (327, 307, 387, and 449), 04/21/25 (409), 04/22/25 (588, 299, and 289), 04/24/25 (368), 04/25/25 (485, 334, and 450), 04/27/25 (272 and 292), 04/28/25 (381), 04/29/25 (261), 04/29/25 (372), 04/30/25 (311) and 05/01/25 (330). Review of Resident #51's medical record revealed the physician was only notified of Resident #51's blood sugar levels over 250 on 03/01/25 and 03/05/25. Interview on 04/30/25 at approximately 10:00 A.M., with the Director of Nursing (DON), verified that Resident #51 did not have their blood sugars monitored as ordered by the physician. DON also verified that Resident #51's physician was only notified on 03/01/25 and 03/05/25. Interview on 04/30/25 at 10:39 A.M., with Nurse Practitioner (NP) #502, verified that a physician should be contacted if a patient is experiencing blood sugars over 250. NP #502 confirmed if he was notified of Resident #51's blood sugar levels, he would have ordered a sliding scale insulin to help the Resident #51 manage their blood sugar levels. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #51's medical record on 05/01/25 revealed no current orders for insulin sliding scale coverage. 3. Review of Resident #30's medical record revealed Resident #30 was admitted to the facility on [DATE]. Diagnoses included acute and chronic respiratory failure, chronic pulmonary disease, peripheral vascular disease, hypertension, hemiplegia, hyperlipidemia, and protein-calorie malnutrition. Resident #30 was accepted by hospice on 01/15/25 Review of Resident #30's MDS assessment dated [DATE] revealed the resident was cognitively intact. Interview on 05/01/25 at 9:00 A.M., with Registered Nurse (RN) #240, verified the binders are kept at each nurses station with hospice information for each resident on hospice. RN #240 was asked for the binder that included hospice information for Resident #30. RN #240 verified she could not locate Resident #30's hospice information in the binders. Interview on 05/01/25 at 11:13 A.M., with DON, verified the facility does not have any documentation of communication or a care plan from hospice for Resident #30. Review of the undated policy titled, Hospice Program revealed when a resident participates in the hospice program, a coordinated plan of care between the facility, hospice agency and resident/family will be developed and shall include directives for managing pain and other uncomfortable symptoms. The care plan shall be revised and updated as necessary to reflect the resident's current status.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to ensure completion of physician ordered treatments to promote wound healing. This affected one (#33) of three residents reviewed for pressure ulcers. The facility census was 65. Findings include: Medical record review for Resident #33 revealed an admission date of 09/19/24. Medical diagnoses included sepsis and diabetes mellitus. Review of the care plan dated 10/22/24 for Resident #33 revealed the resident had the potential for pressure ulcers. Interventions were to administer treatments as orders and monitor for effectiveness. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #33 was cognitively impaired. Her functional status was dependent for eating, oral hygiene, toileting, bathing, dressing, and positioning in bed. Review of the physician's orders dated 03/25/25 revealed an order for the left buttock: cleanse with wound cleanser, apply hydrogel, calcium alginate, cover with border foam dressing every shift for skin integrity. Review of the physician's orders dated 03/25/25 revealed an order for the right buttock: cleanse with wound cleanser, apply hydrogel, calcium alginate, cover with border foam dressing every shift for skin integrity. Review of the physician's orders dated 03/25/25 revealed an order for the right gluteal fold: cleanse with wound cleanser, apply hydrogel, calcium alginate, cover with border foam every shift for skin integrity. Review of the physician's orders dated 03/25/25 revealed an order for the right heel: cleanse with wound cleanser, pay dry, apply skin prep, leave open to air, heel boot for offloading every shift for skin integrity. Review of the physician's orders dated 03/26/25 revealed and order for the left posterior upper thigh: cleanse with wound cleanser, apply hydrogel, calcium alginate, cover with border gauze every day shift for skin integrity. These were missed on 04/11/25, 04/16/25, and 04/21/25. Review of the physician's orders dated 04/21/25 revealed for the sacrum: cleanse sacrum with wound cleanser, pat dry, cover with calcium alginate, cover with sacral border foam. Change twice daily and as needed for wound care. Review of the treatment administration record (TAR) from 04/01/25 through 04/30/25 revealed the all the treatments were blank for documentation of the completion on 04/11/25, 04/16/25, 04/21/25, and 04/25/25. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/30/25 at 2:20 P.M., with the Director of Nursing (DON) confirmed no evidence of the treatments being completed for the listed dates. Review of the policy entitled Wound Care dated 2001, revised October 2010, revealed the following: The following information should be recorded in the resident's medical record: 1. The type of wound care given. 2. The date and time the wound care was given. 3. The position in which the resident was placed. 4. The name and title of the individual performing the wound care. 5. Any change in the resident's condition. 6. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound. 7. How the resident tolerated the procedure. 8. Any problems or complaints made by the resident related to the procedure 9. If the resident refused the treatment and the reason(s) why. 10. The signature and title of the person recording the data. This deficiency represents the noncompliance investigated under Complaint Numbers OH00164520 and OH00164238.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, medical record review, staff and resident interviews, and policy review, the facility failed to ensure safe water temperatures in resident rooms. This affected five (#18, #37, #51, #59, and #60) of five residents reviewed for water temperatures. The facility failed to ensure safe smoking parameters were in place for one (#20) of one resident reviewed for smoking. The facility census was 65. Findings include Observation on 04/28/25 at 10:20 A.M., revealed water temperatures of 144 degrees Fahrenheit (F) for the shared bathroom for Residents #18, #37, #51 and #60 had hot water temperatures. 1. Review of the medical record for Resident #51 revealed an admission date of 02/07/25. Diagnoses included shortness of breath, diabetes, and heart failure. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 was cognitively intact with a Brief Interview Mental Status (BIMS) of 15 and required supervision or touching assistance with toileting. 2. Review of the medical record for Resident #18 revealed an admission date of 05/07/24. Diagnoses included dementia, Alzheimer's disease, and cognitive communication deficit. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 was cognitively impaired with a Brief Interview Mental Status (BIMS) stating resident was rarely/never understood and required supervision or touching assistance with toileting. 3. Review of the medical record for Resident #60 revealed an admission date of 04/01/24. Diagnoses included ataxia, dyspnea, edema and weakness. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #60 was cognitively intact with a Brief Interview Mental Status (BIMS) of 13 and required partial/moderate assistance with toileting. 4. Review of the medical record for Resident #37 revealed an admission date of 12/31/20. Diagnoses included myocardial infarction, hemiplegia and hemiparesis, cerebral infarct, heart disease, and vascular dementia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #37 was significant cognitively impairment with a Brief Interview Mental Status (BIMS) of 00 and required partial/moderate assistance for toileting. Observation on 04/28/25 at 1:10 P.M., with Maintenance Director (MD) #300, who took the temperature of the bathroom sink water and registered at 144.1 degrees F. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview at the time of the observation, with MD #300, confirmed the water temperature was too high and should be around 120 degrees F. MD #300 stated the hot water tank for this room was connected to the kitchen and was high due to the dishwasher. MD #300 verified steam was coming from the faucet. 5. Review of the medical record for Resident #59 revealed an admission date of 06/24/24. Diagnoses included mood disorder, psychosis, traumatic brain injury, and violent behavior. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #59 was significant cognitive impairment with a Brief Interview Mental Status (BIMS) of 03 and was independent toileting. Observation on 04/28/25 at 1:15 P.M., with MD #300 and Resident #59, revealed MD #300 took the temperature of the bathroom sink water for Resident #59 and the water registered at 141.9 degrees F. MD #300 confirmed this was too high and should be around 120 degrees F. MD #300 stated the hot water tank for this room was connected to the kitchen and was high due to the dishwasher. Resident #59 reported the sink water gets very hot. Review of the policy titled, Water Temperatures - Safety, dated 05/10/20 revealed the policy was related more to food service areas but included a chart stating risk of third degree burns occur at 140 degrees F in five seconds and at 148 degrees F at one second. 6. Review of medical record for Resident #20 revealed admission date of 10/02/23. The resident was admitted with diagnoses including Chronic Obstructive Pulmonary Disease, bladder cancer, unspecified dementia, and peripheral vascular disease. Review the quarterly Minimum Data Set (MDS) dated [DATE] revealed he had severely impaired cognition. He required supervision for eating, moderate assistance for transfers, toileting hygiene and maximum assistance for bed mobility. Review of the plan of care revealed a smoking care plan which included interventions to instruct about smoking risks and hazards and to observe clothing and skins for signs of cigarette burns. Record review revealed the last documented smoking assessment for Resident #20 prior to the survey was 05/30/24. Observation on 04/29/25 at 1:06 P.M., was made from inside the activity/dining area of the outside smoking area. Resident #20 was seated in his wheelchair, smoking along with seven other residents and two activity aids. Resident #20 had his cigarette in his left hand, and was observed using his right hand to brush off fallen ashes from his sweat pants. A staff member was observed directly in front of him talking to other staff and residents. After a second observation of the ash dropping, the Activity Manager (AM) #296, who was also present was notified of the observation. Both the surveyor and the AM #296 went outside. AM #296 grabbed a smoking apron and placed it on Resident #20. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/29/25 at 1:10 P.M., directly following the smoking observation, with AM #29 verified ash had fallen onto the sweat pants of Resident #20 and she acknowledged he was not always paying attention to the length of the ash, allowing it to fall onto his clothing. AM #29 further shared she believed he needed an apron, but he was not care planned to have one. AM #29 admitted she had not brought her concerns to anyone's attention. Interview on 05/01/25 at 10:44 A.M., with the Director of Nursing revealed it was her expectation of staff had a safety concern regarding smoking they would bring it to her attention. Review of the policy titled, Resident Smoking and Procedure, dated 2025 documented each resident should be individually assessed to determine whether he can safely smoke without supervision and assess whether he needed an apron. Reassessments should be conducted as necessary.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure incontinence care was provided correctly. This affected one (#7) of one resident reviewed for incontinence care. The census was 65. Findings included: Medical record review for Resident #7 revealed an admission date of 12/30/22. His medical diagnoses included arteriosclerotic heart disease, Schizophrenia, Alzheimer's, diabetes, chronic kidney disease, and convulsions. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 was severely cognitively impaired. His functional status was setup or clean-up assistance for eating, substantial/maximal assistance for toileting, supervision or touching assistance for bed mobility and transfers. He was always incontinent for bladder and codes for a colostomy. He was coded for wandering. Review of the care plan dated 03/16/25 for Resident #7 revealed the resident required staff intervention to complete self-care. Interventions were to assist with toileting needs/incontinence care on routine rounds and as needed when soiled and at resident's request. Assist as needed with wearing/changing incontinence undergarments and toileting hygiene. Check and change on routine rounds and as needed. Observation on 04/28/25 at 2:00 P.M., of incontinence care for Resident #7, revealed Certified Nursing Aide (CNA) #230 had the resident stand at the bedside, pulled his pants down, removed the incontinence product that was moderately wet. CNA #230 then proceeded with a wet washcloths without soap (the soap was observed sitting on the bedside table), took the unsoaped wet wash cloths and wiped from back to front on right side and then back to front on the left side and barely touching the penis to clean. Then placed a new dry incontinence product. Interview on 04/28/25 at 2:15 P.M., with the CNA #230 confirmed the resident was moderately wet, she didn't use soap for the washcloths and she didn't wipe the penis in a thorough manner. Review of the policy titled, Perineal Care dated 10/01/10 revealed: For a male resident: a. Wet washcloth and apply soap or skin cleansing agent. b. Wash perineal area starting with urethra and working outward. (Note: If the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about 3 inches. Gently rinse and dry the area.) (1) Retract foreskin of the uncircumcised male. (2) Wash and rinse urethral area using a circular motion. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(3) Continue to wash the perineal area including the penis, scrotum and inner thighs. Do not reuse the same washcloth or water to clean the urethra. Thoroughly rinse perinea! area in same order, using fresh water and clean washcloth. (Note: If the resident has an indwelling catheter, hold the tubing to one side and support the tubing against the leg to avoid traction or unnecessary movement of the catheter.) Gently dry perineum following same sequence. Reposition foreskin of uncircumcised male. Instruct or assist the resident to turn on his side with his upper leg slightly bent, if able. Rinse washcloth and apply soap or skin cleansing agent. Wash and rinse the rectal area thoroughly, including the area under the scrotum, the anus, and the buttocks. Dry area thoroughly. This deficiency represents the noncompliance investigated under Complaint Numbers OH00164520 and OH00164238.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interviews, and policy review, the facility failed to adequately monitor and implement interventions timely for residents with significant weight loss. This affected three (#18, #26, and #53) residents of eight reviewed for nutrition. The facility census was 65. Findings include: 1. Review of the medical record for Resident #53 revealed an admission date of 08/13/24. Diagnoses included dementia, emphysema, and major depressive disorder. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #53 was not able to complete a Brief Interview for Mental Status (BIMS) because she was rarely/never understood. This resident was assessed to require setup with eating, supervision with toileting, dressing, and transfers, and independent with bathing. Review of the care plan dated 02/04/25 revealed Resident #53 had a nutritional problem related to mechanical altered texture and consistency and underweight. Interventions included administer medications as ordered, provide and serve diet as ordered, provide nectar thick liquids as ordered, and registered dietician to evaluate and make diet change recommendations as needed. Review of the progress note dated 02/04/25 at 5:35 P.M., revealed Resident #53 had a significant weight loss of 6.9 percent (%) in the last 30 days and 8.2% in the last 90 days. Weight loss etiology unknown as no change in oral intake. House supplement 120 milliliters (ml) and weekly weights for four weeks. Review of the physician order dated 03/04/25 revealed Resident #53 was ordered a house supplement two times a day for supplement - nectar consistency. Review of the weights for Resident #53 revealed the following: on 11/05/24: 100 pounds (lbs.), on 12/10/24: 96.8 lbs., on 01/15/25: 98.6 lbs., on 02/01/25: 91.8 lbs., on 03/07/25: 94.2 lbs., on 03/24/25: 94 lbs., and on 04/01/25: 92.4 lbs. There was no evidence of weekly weights being completed. Interview on 04/30/25 at 1:28 P.M., with Dietary Tech (DT) #506 verified weekly weights were not completed after being recommended for a significant weight loss in February. DT #506 also verified house supplement was not ordered until 03/04/25. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #26 revealed an admission date of 08/26/24. Diagnoses included major depressive disorder, schizoaffective disorder, and generalized anxiety disorder (GAD). Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #26 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of zero. This resident was assessed to require setup with eating, partial assistance with toileting, bathing, supervision with dressing and transfers. Review of the care plan dated 04/08/25 revealed Resident #26 had a nutritional problem related to major depression, psychoactive medications, history of refusal of follow up weights. Interventions included administer medications as ordered, providing and served diet as ordered, providing and served supplements as ordered, and registered dietician to evaluate and make diet change recommendations as needed. Review of the progress note dated 09/17/24 at 7:46 P.M. revealed Resident #26 had a significant weight loss for 30 and 90 days. House supplement 237 milliliters (ml) twice a day and weekly weights for four weeks for increased monitoring. Review of the physician order dated 09/17/24 revealed Resident #26 was ordered a house supplement two times a day for 237 milliliters (ml) by mouth. Review of the physician order dated 09/18/24 revealed Resident #26 was ordered weekly weights for four weeks every Thursday. Review of the physician order dated 10/11/24 revealed Resident #26 was ordered Remeron 7.5 milligrams (mg), give one tablet by mouth at bedtime for appetite stimulant. Review of the physician order dated 04/28/25 revealed Resident #26 was ordered house supplement every shift for supplement 237 milliliters (ml) by mouth. Review of the weights for Resident #26 revealed the following: on 08/29/24: 144 lbs., on 09/17/24: 128.4 lbs., on 11/05/24: 130.2 lbs., on 12/10/24: 126.3 lbs., on 01/15/25: 128.2 lbs., on 02/01/25: 130.4 lbs., on 03/07/25: 127.4 lbs., and on 04/01/25: 127.3 lbs. There was no evidence of weekly weights being completed. Interview on 04/30/25 at 1:37 P.M., with Dietary Tech (DT) #506 verified weekly weights were not completed as ordered. 3. Review of Resident #18's medical record revealed an admission date of 05/07/24. Diagnoses include anemia, hypertension, hyperlipidemia, Alzheimer's, dementia, and depression. Review of the MDS assessment dated [DATE] revealed Resident #18 is cognitively impaired. Review of Resident #18's weight on 05/09/24 220 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #18's care plan, initiated 05/14/24, revealed the resident was at risk for potential nutritional problems. Interventions included for the Registered Dietician to evaluate and make diet changes, Occupational Therapist to screen and provide adaptive equipment as needed, and to monitor/document/report to the physician signs and symptoms of malnutrition. Review of resident #18's nutritional assessment dated [DATE] revealed Resident #18 is on a regular diet with thin liquids. Resident #18 is able to feed themselves with no issues noted. Review of Resident #18's weight log revealed the following weights: on 05/14/24: 224 pounds (lbs)., on 05/21/24: 223 lbs., on 05/29/24: 221.5 lbs., on 06/04/24: 221.3 lbs., on 07/16/24: 213.5 lbs., on 08/26/24: 207 lbs., on 09/09/24: 205 lbs., on 10/04/24: 199.8 lbs., and on 10/08/24: 201.5 lbs Review of Resident #18's progress note date 10/08/24 revealed that Resident #18 was triggered for significant weight loss of 10% over six months. Further review of the progress note revealed that resident #18 was consuming 75-100% of meals and a house nutritional supplement of 237 milliliters (ml) once a day was ordered. Review of Resident #18's weight log revealed that no weights were taken in the month of November. Review of Resident #18's weight on 12/10/24 was 189 lbs. Review of Resident #18's progress note dated 12/10/24 revealed that Resident #18 was triggered again for significant weight loss of 6.34% from 10/08/24 to 12/10/24. Further review of the progress note revealed a reweigh was order. Review of Resident #18's weight on 12/17/24 was 189.8 lbs. Review of Resident 18's progress note dated 12/20/24 revealed that Resident #18 reweigh on 12/17/24 confirms weight loss. Further review revealed that Resident #18 was accepting of his diet and no new recommendations were given. Review of Resident #18's weight on 01/10/25 was 185.4 lbs. Review of Resident #18's progress note dated 01/10/25 revealed that he was triggered for significant weight loss of 8% in 90 days and 13.2% in 180 days. Further review revealed that Resident #18 was accepting his diet and weekly weights were ordered. Review of Resident #18's weight log revealed: on 01/15/25: 185.4 lbs. and on 02/01/25: 179.6 lbs. Review of Resident #18's nutritional assessment dated [DATE] revealed an recommendation to initiate weekly weights and increase the house nutritional supplement to 237 ml twice a day. Review of Resident #18's weight log revealed on 03/10/25: 181.6 lbs. and on 03/24/25: 178.8 lbs. Review of Resident #18's progress note dated 03/25/25 revealed Resident #18 had a weight loss of 26.2 pounds in 180 days which was a loss of 12.8%. Further review revealed a recommendation that the physician should be notified. Review of Resident #18's weight on 04/01/25 was 174.6 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #18's progress note dated 04/08/25 revealed Resident #18 had a weight loss of 25.2 pounds in 180 days which was a loss of 12.6%. Further review revealed a recommendation the physician should be notified. Interview on 04/30/25 at 3:54 P.M.,with Registered Dietician (RD) #504 revealed the nutritional assessments were completed by diet technicians, however she reviewed the residents record in October and added the first house nutritional supplement. RD #504 confirmed that Resident #18 was still under excessive weight loss review. RD #504 revealed Resident #18's Body Mass Index (BMI) was within normal limits and therefore his nutritional needs were met. Interview on 04/30/25 at 6:49 P.M., with Regional Nurse #508 revealed Resident #18's weight loss was desired, but confirmed that no documentation of a weight loss plan was recorded. Regional Nurse #508 confirmed that Resident #18 continued to lose weight with interventions in place and the weekly weights were not documented when ordered. Regional Nurse #508 revealed the plan is to maintain Resident #18 around 170 lbs.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 4. Medical record review for Resident #1 revealed an admission date of 09/06/18. His medical diagnoses included atrial fibrillation, cancer, coronary artery disease, heart failure, and peripheral vascular disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 was cognitively intact. Review of the current physician orders and times of medication administration dated 04/27/25 for Resident #1 revealed Coreg 12.5 milligrams (mg) to give one twice a day was scheduled at 4:00 P.M. and given at 6:55 P.M. Hydralazine 50 mg to give one three times a day was scheduled for 8:00 P.M. and was given at 12:41 A.M. Interview with Resident #1 on 04/28/25 at 10:11 A.M. revealed the agency nurse's were awful and his medications weren't on time. He reported there are times when he gets him morning medications in the evening, but didn't know a date or time. 5. Medical record review for Resident #7 revealed an admission date of 12/30/22. His medical diagnoses included arteriosclerotic heart disease, Schizophrenia, Alzheimer's, diabetes, chronic kidney disease, and convulsions. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 was severely cognitively impaired. His functional status was setup or clean-up assistance for eating, substantial/maximal assistance for toileting, supervision or touching assistance for bed mobility and transfers. He was always incontinent for bladder and codes for a colostomy. He was coded for wandering. Review of the current physician orders and times of medication administration dated 05/01/25 for Resident #7 revealed Depakote 250 mg to give one twice a day, Ranexa 1000 mg, to give one twice a day, Famotidine 20 mg. to give one twice a day, Levetiracetam 500 mg. to give one twice a day for convulsions, Sucralfate one gram to give one three times a day were all scheduled at 8:00 A.M. and given at 11:07 A.M. 6. Medical record review for Resident #367 revealed an admission date of 03/11/25. Her medical diagnoses included chronic pulmonary obstruction, depression, hyperlipidemia, anxiety, atrial fibrillation, diabetes, and hypertension. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #367 was cognitively intact. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the current physician orders and times of medication administration dated 04/27/25 for Resident #367 revealed Theophylline Extended Release (ER) to give 300 mg twice a day, Lactulose to give 30 milliliters (ml) twice a day, Apixaban 5 mg to give one twice a day, Ativan to give one mg twice a day, Budesonide-Formoterol Fumarate Inhalation Aerosol to give two puffs twice a day, Albuterol one vial to give four times a day, all scheduled to be given at 8:00 A.M. and given at 10:49 A.M. Further review of the medications revealed Theophylline Extended Release (ER) to give 300 mg twice a day, Lactulose to give 30 milliliters (ml) twice a day, Apixaban 5 mg to give one twice a day, Ativan to give one mg twice a day, Budesonide-Formoterol Fumarate Inhalation Aerosol to give two puffs twice a day, Albuterol one vial to give four times a day were scheduled for 8:00 P.M. and not given till 12:26 A.M. Interview with Resident #367 on 04/28/25 at 3:16 P.M. revealed her medications were given late. 7. Medical record review for Resident #368 [NAME] revealed an admission date of 04/23/25. Medical diagnoses included hypertension, hyperlipidemia, and depression. Review of the admission progress note dated 04/23/25 revealed Resident #368 was cognitively intact. Functional status was unsteady gait and balance was poor. Review of the current physician orders and times of medication administration dated 04/27/25 for Resident #368 revealed to give Ranolazine ER 500 mg one twice a day, Budesonide-Formoterol Fumarate Inhalation Aerosol to give two puffs twice a day, Spiriva Respimat Inhalation 2.5 micrograms (mcg) to give two inhalation two times a day, Risperdal 4 mg to give one twice a day, Carvedilol 12.5 mg, Metformin 1000 to give twice a day, Doxycycline 100 mg to give one two times a day, Carafate 1 gram to give one four times a day were all scheduled for 8:00 A.M. and given at 9:32 A.M. Further review revealed Lantus to give 40 units at bedtime, Famotidine 20 mg to give one at bedtime, Budesonide-Formoterol Fumarate Inhalation Aerosol to give two puffs twice a day, Risperdal 4 mg to give one twice a day, Ranolazine ER 500 mg to give twice a day, Spiriva Respimat Inhalation 2.5 micrograms (mcg) to give two inhalation two times a day, Trazadone 300 mg to give one at bedtime, and Vistaril 50 mg to give one capsule three times a day. All these medications were scheduled at 8:00 P.M. and given at 12:43 A.M. Interview with Resident #206 on 04/28/25 at 10:05 A.M. revealed his medications were messed up and late. Interview with the Licensed Practical Nurse (LPN) #206 on 05/01/25 at 7:12 A.M., revealed she was the nurse who worked the night shift on 04/27/25 and verified she was late with the medications. LPN #206 stated it was due to having 35 residents and dealing with behaviors on her assignment. LPN #206 reported it was better to be late then to not give them at all. She reported there was enough staff. Interview with the LPN #281 on 05/01/25 at 8:03 A.M., revealed she worked dayshift on 04/27/25. LPN #281 confirmed she was late with her medications because a resident had to go out to the hospital for seeping of his legs and she got behind. LPN #281 reported there were other nursing staff working, but she didn't ask them to help her get caught up because they were busy too. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the policy titled Medication Administration dated 2001 revealed medications are administered within one (l} hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). This deficiency represents the noncompliance investigated under Complaint Number OH00164520. Based on record review, staff and resident interviews, review of Medscape resource website and policy review, the facility failed to ensure extended release medications were not crushed, administer medications as ordered and/or in a timely manner. This affected six (#1, #7, #26, #266, #366, and #367) of 11 residents reviewed for medication administration. The facility census was 65. Findings included: 1. Review of medical record for Resident #366 revealed admission date of 02/19/25. The resident was admitted with diagnoses including cellulitis, morbid obesity, type two diabetes mellitus, unstageable pressure ulcer of right heel. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed she had a Brief Interview Mental Status (BIMS) score of 13 indicating intact cognition. She required set up for eating, was dependent with toileting hygiene, maximum assistance for showers, transfers and moderate assistance for bed mobility. Review of the physician orders revealed an order for Coreg (hypertension) 6.25 milligrams (mg) twice daily, Torsemide (Congestive heart failure) 40 mg twice daily with a start date of 02/19/25, Allopurinol (gout) 100 mg (mg) daily, Buspirone (depression) 10 mg daily, Protonix (reflux) 40 mg daily, and Paxil (depression) 40 mg daily with a start date of 02/20/25. Record review of the February Medication Administration Record (MAR) revealed Coreg was scheduled for 8:00 A.M. and 8:00 P.M., with no documentation it had been administered on 02/20/25 or at 8:00 A.M. on 02/21/25, 02/22/25, or 02/23/25; Torsemide was scheduled for 8:00 A.M. and 8:00 P.M., with no documentation it had been administered on 02/20/25 or at 8:00 A.M. on 02/21/25, 02/22/25, or 02/23/25 at 8:00 A.M. or 8:00 P.M.; Allopurinol, Buspirone and Paxil were scheduled for 8:00 A.M., with no documentation they were administered as prescribed on 02/20/25, 02/21/25, 02/22/25 or 02/23/25; and Protonix was scheduled at 6:00 A.M., with no documentation it had been administered as prescribed on 02/21/25, 02/22/25 or 02/23/25. Interview on 05/01/25 at 11:22 A.M., with the Director of Nursing verified there was no documentation medications for Resident #366 had been administered as prescribed on 02/20/25 through 02/23/25. 2. Review of medical record for Resident #266 revealed admission date of 06/24/24, with diagnoses including major depression disorder recurrent with severe psychotic symptoms, dementia and anxiety. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed he had severely impaired cognition required set up assistance for eating and supervision for bed mobility, transfers and toileting hygiene. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of medication administration on 04/29/25 at 7:58 A.M., with Licensed Practical Nurse (LPN) #293, for Resident #266, revealed he administered Vascepa (statin) one gram (gm) two tablets, Ciprofloxin (antibiotic) 250 milligrams (mg), Eliquis (anticoagulant) 2.5 mg, Lasix (diuretic) 20 mg, Gabapentin (neuropathy) 800 mg, Senna-Plus (laxative) 8.6 mg/50 mg, Refresh Eye Drops (eye lubricant) one drop for each eye, and Namenda (Dementia) 10 mg. Review of the physician orders revealed a physician order for Namenda five mg daily with a start date of 03/17/25. Interview on 04/29/25 at 8:42 A.M. , with LPN #293 verified he had given 10 mg of Namenda to Resident #266 in error. 3. Review of medical record for Resident #26 revealed admission date of 06/24/24 with diagnoses including major depression disorder recurrent with severe psychotic symptoms, dementia and anxiety. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed had severely impaired cognition required set up assistance for eating and supervision bed mobility, transfers and moderate assistance for toileting hygiene. Observation on 04/29/25 at 7:48 A.M., with Licensed Practical Nurse (LPN) #293 was observed to crush Plavix (anticoagulant) 75 milligrams (mg) and Wellbutrin Extended Release 150 mg and added it to a medicine cup containing pudding. He then opened a capsule of Auvelity (depression) 45 mg/105 mg, added it to the pudding and mixed it together prior to administering it to Resident #293. Interview on 04/29/25 at 8:42 A.M. , with LPN #293 verified he crushed the medications. Review of Medscape website at https://reference.medscape.com/drug/wellbutrin-aplenzin-bupropion-342954#91 revealed, Swallow the tablets whole. Do not crush or chew the tablets. Doing so can release all of the drug at once, increasing the risk of side effects.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, medical record review, staff interview, review of the undated manufacture guidelines, and review of Medscape resource website, the facility failed to ensure the medication error rate did not exceed five percent when three medication errors were observed of 25 opportunities resulting in an error rate of 12 percent. This affected three (#26, #266, and #368) of four residents observed for medication administration. The facility census was 65. Findings include: 1. Review of medical record for Resident #266 revealed admission date of 06/24/24, with diagnoses including major depression disorder recurrent with severe psychotic symptoms, dementia and anxiety. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed he had severely impaired cognition required set up assistance for eating and supervision for bed mobility, transfers and toileting hygiene. Observation of medication administration on 04/29/25 at 7:58 A.M., with Licensed Practical Nurse (LPN) #293, for Resident #266, revealed he administered Vascepa (statin) one gram (gm) two tablets, Ciprofloxin (antibiotic) 250 milligrams (mg), Eliquis (anticoagulant) 2.5 mg, Lasix (diuretic) 20 mg, Gabapentin (neuropathy) 800 mg, Senna-Plus (laxative) 8.6 mg/50 mg, Refresh Eye Drops (eye lubricant) one drop for each eye, and Namenda (Dementia) 10 mg. Review of the physician orders revealed a physician order for Namenda five mg daily with a start date of 03/17/25. Interview on 04/29/25 at 8:42 A.M. , with LPN #293 verified he had given 10 mg of Namenda to Resident #266 in error. 2. Review of medical record for Resident #26 revealed admission date of 06/24/24 with diagnoses including major depression disorder recurrent with severe psychotic symptoms, dementia and anxiety. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed had severely impaired cognition required set up assistance for eating and supervision bed mobility, transfers and moderate assistance for toileting hygiene. Observation on 04/29/25 at 7:48 A.M., with Licensed Practical Nurse (LPN) #293 was observed to crush Plavix (anticoagulant) 75 milligrams (mg) and Wellbutrin Extended Release 150 mg and added it to a medicine cup containing pudding. He then opened a capsule of Auvelity (depression) 45 mg/105 mg, added it to the pudding and mixed it together prior to administering it to Resident #293. Interview on 04/29/25 at 8:42 A.M. , with LPN #293 verified he crushed the medications. Review of Medscape website at https://reference.medscape.com/drug/wellbutrin-aplenzin-bupropion-342954#91 revealed, Swallow the tablets whole. Do not crush or chew the tablets. Doing so can release all of the drug at once, increasing the risk of side effects. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of medical record for Resident #368 revealed admission date of 04/29/25 with diagnoses including fracture of unspecified part of left femur, methicillin resistant staphylococcus aureus and type two Diabetes Mellitus. The resident remained in the facility. Observation on 05/01/25 at 9:08 A.M., of Registered Nurse (RN) #240 of medication observation for Resident #368 revealed her blood glucose was 348 which required eight units of insulin. RN #240 was observed to clean the hub of the Lispro insulin pen before applying the needle. She then went to the bedside of Resident #368 and dialed the pen to the number eight. RN #240 then prepared the abdomen of Resident #368 by cleaning an area with an alcohol swab and proceeded to inject the medication. Interview on 05/01/25 at 9:12 A.M., directly following the observation, RN #240 verified she did not prime the needle prior in preparation to administering the required eight units. Review of the undated manufacture guidelines for Lispro documented the pen must be primed to a stream of insulin before each injection to make sure the pen is ready to dose. If the pen is not primed too little or too much insulin may be given. This deficiency represents the noncompliance investigated under Complaint Number OH00164520.

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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 observations, record review, review of physician orders, staff interview, and review of manufacture guidelines, the facility failed to ensure residents were free from significant medication errors. This affected two (#366 and #368) of five residents reviewed for medications. The facility census was 65. Findings include: 1. Review of medical record for Resident #366 revealed admission date of 02/19/25. The resident was admitted with diagnoses including cellulitis, morbid obesity, type two diabetes mellitus, unstageable pressure ulcer of right heel. Review of the admission Minimum Data Set (MDS) dated [DATE] revealed she had a Brief Interview Mental Status (BIMS) score of 13 indicating intact cognition. She required set up for eating, was dependent with toileting hygiene, maximum assistance for showers, transfers and moderate assistance for bed mobility. Review of the physician orders revealed an order for Lispro (fast acting insulin) 100 units per (/) milliliter (ml) sliding scale before meals and at bedtime. If blood glucose 150 to 200 give three units, if 201 to 250 give six units, if 251 to 300 give nine units, if 301-350 give 12 units, if 351-400 give 12 units, if 401-450 give 18 units, if over 450 call physician with a start date of 02/19/25. Review of the February Medication Administration Record (MAR) revealed blood glucose was scheduled to be obtained at 7:00 A.M., 11:00 A.M., 4:00 P.M. and 8:00 P.M. Further review revealed no documentation blood glucose was checked at all on 02/20/25, and was only documented at 8:00 P.M. on 02/21/25, 02/22/25 and 02/23/25. Interview on 05/01/25 at 11:22 A.M. with the Director of Nursing verified there was no documentation glucose monitoring for Resident #366 had been obtained as ordered on 02/20/25 through 02/23/25, and no insulin coverage was provided if needed. 2. Review of medical record for Resident #368 revealed admission date of 04/29/25 with diagnoses including fracture of unspecified part of left femur, methicillin resistant staphylococcus aureus and type two Diabetes Mellitus. Observation on 05/01/25 at 9:08 A.M., of Registered Nurse (RN) #240 of medication observation for Resident #368 revealed her blood glucose was 348 which required eight units of insulin. RN #240 was observed to clean the hub of the Lispro insulin pen before applying the needle. She then went to the bedside of Resident #368 and dialed the pen to the number eight. RN #240 then prepared the abdomen of Resident #368 by cleaning an area with an alcohol swab and proceeded to inject the medication. Interview on 05/01/25 at 9:12 A.M., directly following the observation, RN #240 verified she did not prime the needle prior in preparation to administering the required eight units. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the undated manufacture guidelines for Lispro documented the pen must be primed to a stream of insulin before each injection to make sure the pen is ready to dose. If the pen is not primed too little or too much insulin may be given. This deficiency represents the noncompliance investigated under Complaint Number OH00164520.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview and policy review, the facility failed ensure medications were not left unattended in residents rooms and safely store medications. This affected three residents (#7, #9 and #41) directly and had the potential to affect the 16 residents who resided on Unit #2. The facility census was 65. Findings included: 1. Medical record review for Resident #7 revealed an admission date of 12/30/22. His medical diagnoses included arteriosclerotic heart disease, Schizophrenia, Alzheimer's, diabetes, chronic kidney disease, and convulsions. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #7 was severely cognitively impaired. His functional status was setup or clean-up assistance for eating, substantial/maximal assistance for toileting, supervision or touching assistance for bed mobility and transfers. He was always incontinent for bladder and codes for a colostomy. He was coded for wandering. Observation on 04/28/25 at 2:59 P.M., revealed Licensed Practical Nurse (LPN) #293 on 04/28/25 at 2:59 P. M. revealed LPN #293 was seen in Resident #7's room with a medicine cup of what looked like vanilla pudding. He walked out of the room with the medicine cup and walked down the hall to his medication cart and threw the cup in the trash. Interview and observation with the LPN #293 on 04/28/25 at 3:00 P.M., revealed the LPN #293 took the medication cup out of the trash and it looked like vanilla pudding with different colored specks in the pudding. LPN #293 said the cup was pudding with what looked like crushed medications left over from the night before and he was discarding it in the trash. He confirmed the medications were left at the bedside and should not be. Interview with Registered Nurse (RN) #512 on 05/01/25 at 8:07 A.M. revealed he worked at the facility several month ago and took care of Resident #7. RN #7 reported he had left a cup of medications in the room and the family came into the facility had a problem with him leaving the meds in the room. RN #512 reported he thought the resident would be able to take the medications if he left the room, but said this wasn't the policy and procedure for this. The nurses were supposed to watch the residents take there medications. 2. Review of the medical record for Resident #9 revealed an admission date of 03/08/25. Diagnoses included abdominal pain, spinal stenosis, gastritis and malnutrition. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9 had moderate cognitive impairment with a Brief Interview Mental Status (BIMS) of 9. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of active monthly physician orders for April 2025 revealed orders for 8:00 A.M, to include: Aripiprazole oral tab 5 milligram mg, vision plus oral capsule to give one capsule, Paxil oral tab 10 mg once daily to be given along with 20 mg tab and 10 mg tablet for 30 mg total, Neurontin Oral Capsule 100 mg, Metoprolol Tartrate oral tab 50 mg, Naloxegol Oxalate oral tab 25 mg, Pantoprazole Sodium oral tab 40 mg once daily, Sennosides oral tab 8.6 mg to give two tablets once daily, Eliquis oral tab 5 mg, Torsemide oral tab 20 mg, Famotidine oral tab 20 mg, and Levothyroxine Sodium tab 125 micrograms once daily. Review of the Medication Administration Record (MAR) dated 04/28/25 revealed 13 orders/pills were signed off as given during the morning shift medication pass. Observation on 04/28/25 at 10:08 A.M., revealed a cup of medications were seen to be left on the bedside table with staff out of sight of resident and the medications. Interview and observation on 04/28/25 at 10:09 A.M., with Registered Nurse (RN) #513 confirmed a cup of pills was left at the bedside. RN #513 confirmed the pill contained eight pills with seven different medications. At first RN #513 stated the night shift staff left that cup at bedside and then stated resident wasn't feeing well and gotten sick so the aide was cleaning her up and that was the reason she left the pills in the resident's room Interview on 04/28/25 at 11:00 A.M., with RN #513 confirmed she documented in the MAR that resident had been administered all morning medications (13 pills). RN #513 revealed she was passing pills when resident got sick and had to stop and resume at a later time. RN #513 was unable to identify what medications were in the cup and left out in Resident's room. Interview on 04/28/25 at 3:00 P.M., with Resident #9 confirmed staff regularly leave medications at bedside and leave the room while leaving the pills. 3. Observation on 04/28/25 at 9:39 A.M., revealed Resident #41 appeared asleep in his bed. The bedside table was beside the bed and a medicine cup containing multiple pills was observed. Interview at the time of the observation, with Licensed Practical Nurse (LPN) #304 revealed she had not given any pills to Resident #41 this day. LPN #304 stated she had entered the room, but he was not awake and she was going to return later to give his morning pills. LPN #304 verified there were pills in the medicine cup on his bedside table. LPN #304 removed the medicine cup from the bedside table. She counted the pills and stated there were 12 pills and one capsule which she removed from the room and discarded. Interview on 04/30/25 at 4:00 P.M., with Clinical Regional Licensed Practical Nurse (CRLPN) #500 revealed Resident #41 did not have an order for self-medication administration. Review of the undated facility policy, Administering Medications residents may self-administer medication only if the attending physician in conjunction with the interdisciplinary care team, has determined they have the decision-making capacity to do so safely. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Observation on 04/29/25 at 9:07 A.M., with LPN #304 of the medication cart revealed there was one loose red pill and one loose white pill in the top drawer. There was one loose vial of Budesonide (inhalation medication for asthma) vial in the bottom of the medication drawer. There were no boxes for Budesonide of the medication in the drawer. Interview on 04/29/25 at 9:07 A.M., with LPN #304 verified there were two loose pills in the top drawer of the medication cart and one vial of Budesonide in the bottom drawer. She acknowledged the medication should be stored outside of the original container and discarded the medication. Review of the policy, Medication Labeling and Storage revised February 2023 documented Medications and biologics are stored in the packaging, containers or dispensing systems which they are received. Medications are to be stored in an orderly manner. This deficiency represents non-compliance investigated under Complaint Number OH00164238.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Shepherd Village	422 North Burnett Road Springfield, OH 45503

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, medical record record review, meals substitute log review, menu review, diet tech audit review, and policy review, the facility failed to follow meal tickets and scheduled menu and an updated/ accurate substitution log. This affected two (#16 and #30) of three residents reviewed for nutrition with potential to affect all residents who receive meals from the dining room. Facility identified all facility residents eat food from the kitchen. The facility census was 65. Findings include: 1. Review of the medical record for Resident #30 revealed an admission date of 08/13/24. Diagnoses included pneumonia, malnutrition, hemiplegia, heart failure, vascular disease, and respiratory failure. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #30 had moderate cognitive impairment with a Brief Interview Mental Status (BIMS) of 11. Interview and observation on 04/28/25 at 12:34 P.M. with Resident #30 revealed the food that was served did not match the meal ticket. Resident #30's food ticket was dated 04/27/24, Sunday lunch and stated resident had a mechanical diet. It also stated resident should receive broccoli and potato soup, basked ziti with four cheese, shredded lettuce, and applesauce. Resident #7 only had a cup of vegetable soup and a small ice cream cup on her tray. Resident #30 reported what she gets served never matches the ticket or the menu. Resident #30 stated she was still hungry and would like more to eat than just a cup of soup. Interview and observation on 04/28/25 at 12:35 P.M., with Certified Nurse Aide #282 confirmed residents tray items did not match the ticket and confirmed the kitchen did not typically follow the posted menu and they heard regular complaints from residents about the items not matching the tickets on the tray. 2. Review of Resident #16's medical record revealed an admissions date of 02/07/25. Diagnoses include coronary artery disease, hypertension, diabetes mellitus, seizures, anxiety, and depression. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 is cognitively intact. Interview with Resident #16 on 04/28/25 at 3:09 P.M., revealed she does not receive a menu for each meal. Resident #16 stated that she doesn't know what she will be getting for each meal. Observation of the lunch served on 04/28/25 at approximately 12:30 P.M., revealed that chicken salad sandwiches were being served instead of the meat loaf that was listed on the scheduled menu for the day. Interview dated 04/29/25 at 12:53 P.M., with Kitchen Manager (KM) #237 confirmed the resident meals do not always match what was on the menu. KM #237 revealed the facility was unable to find the complete substitution log. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of substitution log dated April 2025 revealed the 04/28/25 change in the lunch meal was not included on the substitution log. It mentioned dinner meal it added chicken salad in place of salad but included no mention of switching the meat loaf and the mashed potatoes and gravy and the fruit cup. Observation and interview on 04/29/25 at 3:10 P.M., with Diet Tech #506 revealed she typically would do a test tray and audits about monthly and revealed in recent audits she completed found facility did not follow the menu or spreadsheets. She also revealed when she had requested the substitution logs for the last two months, facility was unable to supply any evidence of the substitution log. Review of facility diet tech audit dated 03/25/25 revealed standard recipes (including puree recipe) was not being followed, and substitution log was not found. Review of facility diet tech audit dated 04/29/25 revealed nutrition recommendations were not addressed from the previous visit. Menu with spreadsheets were not followed, and substitution log was not found. Review of the menu for 04/28/25 revealed the lunch meal included homemade meatloaf, mashed potatoes and gravy, bread, peas and carrots, and mixed fruit. Review of facility policy titled, Menus, dated 04/25/24 revealed menus should be prepared in advance. Menus should be approved by the dietician if the meal changes for any reason from the planned menu, the reason for the change should be documented and maintained in the kitchen. This deficiency represents the noncompliance investigated under Complaint Number OH00164520.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on an observation, staff and resident interviews, medical record review, diet tech audit review, and policy review, the facility failed to ensure food had a palatable taste and was served at an appetizing temperature. This affected four (#1, #16, #30, and #367) of six residents reviewed for dietary needs. The facility identified all residents eat food from the kitchen. The facility census was 65. Findings include: 1. Review of the medical record for Resident #30 revealed an admission date of 08/13/24. Diagnoses included pneumonia, malnutrition, hemiplegia, heart failure, vascular disease, and respiratory failure. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #30 had moderate cognitive impairment with a Brief Interview Mental Status (BIMS) of 11. Interview on 04/29/25 at 4:32 P.M. with Resident #7 revealed food wasn't good and didn't have good taste. 2. Review of the medical record for Resident #367 revealed an admission date of 03/11/25. Diagnoses included chronic obstructive pulmonary disease, depression, atrial fibrillation, and diabetes. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #367 was cognitively intact with a Brief Interview Mental Status (BIMS) of 15. Interview on 04/28/25 at 3:16 P.M., with Resident #367 revealed food was not good and was cold. 3. Review of the medical record for Resident #1 revealed an admission date of 09/06/18. Diagnoses included atrial fibrillation, diabetes, heart disease and dysphasia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 was cognitively intact with a Brief Interview Mental Status (BIMS) of 15. Interview on 04/28/25 at 10:25 A.M., with Resident #1 revealed food that was served was not hot. Review of facility diet tech audit dated 03/25/25 revealed puree food looked pasty, lacked flavor and appearance, standard recipes (including puree recipe) not being followed. Review of facility diet tech audit dated 04/29/25 revealed nutrition recommendations were not addressed from the previous visit. Food was not cooked in a way to conserve nutritive value, flavor and appearance. Upon diet tech test tray it was determined the food was very salty and unappealing, food was cold and below an acceptable range. 4. Review of Resident #16's medical record revealed an admissions date of 02/07/25. Diagnoses include coronary artery disease, hypertension, diabetes mellitus, seizures, anxiety, and depression. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 is cognitively intact. Interview with Resident #16 on 04/28/25 at 3:09 P.M. revealed the food being served does not taste good. Resident #16 stated that the food is not served warm enough and is often cold. Observation on 04/29/25 at 11:55 A.M., with Dietary [NAME] #214 revealed prior to the start of tray line, the cream of rice had a temperature of 140 degrees, the pureed [NAME] chicken had a temperature of 135 degrees, the pureed vegetables had a temperature of 148 degrees and the regular [NAME] chicken had a temperature of 176 degrees. Observation on 04/29/25 at 12:41 P.M., with Dietary [NAME] #214 revealed when plating the test tray, the cream of rice had a temperature of 137 degrees, the pureed vegetables had a temperature of 118 degrees and the regular [NAME] chicken had a temperature of 155 degrees. When asked about what temperature staff was looking for the tray line items, Dietary [NAME] #214 revealed 165-175 degrees. The test tray left the kitchen at 12:47 P.M. Observation and interview on 04/29/25 at 1:06 P.M., with Kitchen Manager #237 revealed the cream of rice had a temperature of 94 degrees, the pureed vegetables had a temperature of 91 degrees and the regular [NAME] chicken had a temperature of 92 degrees. Kitchen Manager #237 along with survey team tried the items and confirmed they tasted cold and the [NAME] chicken tasted very salty. Kitchen Manager #237 also revealed the cream of rice tasted bland. Kitchen Manager #237 revealed facility had metal warming dish to keep plates warm and don't use them but stated we could start using them. Observation and interview on 04/29/25 at 3:10 P.M., with Diet Tech #506 revealed she typically with do a test tray and audits about monthly and revealed the last two audits she completed found facility palatability concerns with taste and temperature. She revealed food should be served over 120 degrees and reported she also tried the meals this date and found the items to be cold and the meat to be salty. She revealed she also spoke with residents in the dining room who also confirmed the food was cold and the meat was salty. Review of the policy titled, Palatability and Nutritive Value, dated 06/27/23 revealed food shall be prepared, held and served in a manner that preserves nutritive value and palatability. Hot foods would be held at 135 degrees. The facility shall make best efforts to present hot foods hot at point of service by using thermal lids and bases and thermal pellets as needed. Food service staff shall monitor palatability of food at point of service by periodic test tray evaluation. This deficiency represents the noncompliance investigated under Complaint Number OH00164520.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, recipe review and diet tech audit review, the facility failed to ensure pureed food was made to the correct consistency and the menu was followed. This affected four (#27, #46, #54, and #62) of four residents who received purred diets. The facility census was 65. Findings include: Observation and interview on 04/29/25 at 11:14 A.M., with Dietary [NAME] #214 revealed she made four servings of pureed [NAME] chicken. She placed four, four ounce scoops into the blender along with one and a half cups of chicken gravy followed by an additional cup of gravy for a total of two and a half cups of gravy. Dietary [NAME] #214 revealed she was looking for a mashed potato consistency. The mixture was blended and poured into a container without ever scraping the sides. The final mixture was tasted by staff and surveyors and found several chunks of chicken which Dietary [NAME] #214 acknowledged. The mixture was returned to the blender and staff continued to blend to a smoother consistency. Observation on 04/29/25 at 12:08 P.M., revealed Dietary Staff #214 made up a puree dish on the tray line. The [NAME] chicken was scooped onto the late and spread out due to being overly thinned with gravy. Interview on 04/29/25 at 1:06 P.M., with Kitchen Manager #237 confirmed puree food should hold a shape and not spread on the plate. Interview on 04/29/25 at 3:10 P.M., with Diet Tech #506 revealed puree should be a smooth consistency without lumps or chunks of any kind and should hold a scoop shape. She revealed she completed test trays every few weeks and revealed she had brought up concerns related to puree food being chunky and not to the correct consistency. Diet Tech #506 also revealed staff should be using a recipe with instructions for how but thinning liquid (i.e. gravy) and how much thickener should be used. Review of the undated recipe for [NAME] chicken for making puree texture revealed gravy or thinning agent should be added in measurements of tablespoons. It did not given any instructions for using two and a half cups of thinning liquid (gravy) for four servings. Review of diet tech audit dated 03/25/25 revealed puree food looked pasty, lacked flavor and appearance, standard recipes (including puree recipe) not being followed. Review of diet tech audit dated 04/29/25 revealed nutrition recommendations were not addressed from the previous visit. Standard recipes (including puree recipe) not being followed. It was also noted puree food not made to proper consistency, upon diet tech test tray it was determined the food was very salty and unappealing, food was cold and below an acceptable range. This deficiency represents the noncompliance investigated under Complaint Number OH00164520.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews and policy review, the facility failed to ensure food was stored in a safe and sanitary manner. This had the potential to affect all 65 residents. The facility census was 65. Findings include: Observation of the walk in freezer on 04/28/25 at 8:49 A.M. revealed frozen waffles in a bag without a date. Ice was observed on the tops of boxes of Mighty Shakes and B/C Topping that were stored under the freezer condenser. Interview with the Kitchen Manger (KM) #237 confirmed that the frozen waffles did not have a date. KM #237 confirmed that the condenser appeared to be leaking and creating a build up of ice on the boxes stored below. Observation on 04/28/25 at 8:54 A.M. revealed Dietary Aide (DA) #284 testing the chemical dish machine with a chlorine test strip that appeared to be a light purple. Interview with DA #284 verified that the test strip showed that the chlorine concentration in the dish machine was at 25 parts per million (PPM). DA #284 verified that the dish machine should have a concentration of 50-100 PPM of chlorine. Observation of the refrigerator on 04/28/25 at 8:55 A.M. revealed an open bottle of ketchup dated 04/19/25, 26 containers of thickened cranberry cocktail with an expiration date of 04/18/25, 15 containers of thickened lemonade with an expiration date of 02/05/25, an open package of slice turkey without a date and a carton of B/C topping without a date. Interview with DD #237 confirmed that the ketchup, cranberry cocktail, lemonade were past their expirations date. KM #237 confirmed that the sliced turkey and B/C topping were not dated. Observation of the dry stock on 04/28/25 at 9:08 A.M. revealed a container of flour without a date marked, a container of egg noodles without a date marked, and a box of care thickened hot cocoa mix with an expiration date of 03/01/25. Interview with KM #237 confirmed that both containers did not have a date marked and that the cocoa mix was past the expiration date. Observation in the kitchen on 04/28/25 at 9:14 A.M. revealed an open bag of hot dog buns without a date marked. Interview with KM #237 confirmed that the hot dog buns did not have a date on the bag. Observation of the preparation of the pureed lunch menu on 04/29/25 at 11:18 A.M. revealed Dietary [NAME] (DC) #214 pour the pureed [NAME] chicken into a metal pan that had a yellow residue inside. Interview DC #214 confirmed that there was a residue in the metal pan and that she believed that it was a residue from chicken base. DC#214 confirmed that she grabbed the pan from the stack of clean pans that were stored under the preparation table. Observation of the dry stock on 04/29/25 at 11:38 A.M. revealed an open bags of spaghetti noodles, navy beans and white rice without a date marking when they were opened. Interview with KM #237 verified that the bags were not marked with an opened date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of the walk in cooler on 04/29/25 at 11:39 A.M. revealed raw hamburger meat being stored above gallons of milk and bags of cheese. Interview with KM #237 confirmed that the raw meat was stored above ready to eat food. Further observation of the lunch service on 04/29/25 at 12:10 P.M. revealed KM #237 enter the kitchen with a metal pot and filled the pot with water at the prep sink. KM #237 then placed several hot dogs into the pot and placed in on the stove. A residue was then observed on the outside of the pot. Interview with KM #237 verified that the pot was dirty. Observation on 04/29/25 at 12:27 A.M. revealed DC #214 scoop a serving of white rice on top of a green residue that was on the plate. DC #214 scraped the rice into the trash to reveal that a green residue was on the plate. DC #214 confirmed that the plate was dirty. Observation of the dish machine on 04/29/25 at 1:25 P.M. revealed that the water temperature gage was at 115 degrees Fahrenheit for the entire cycle. KM #237 tested the chlorine sanitizer in the dish machine and the test strip appeared to be a light purple. Interview with KM #237 verified that the water temperature gage seemed to be stuck at 115 degrees Fahrenheit and the concentration of the chlorine was at 25 PPM. Observation of lunch service on 04/29/25 at 12:14 P.M., revealed Dietary Aide (DA) #284 lift the lid of the trash can to throw away disposable gloves. DA #284 then began assembling items for the lunch trays, including handling silverware, cups and plates without washing her hands. Interview with DA #284 on 04/29/25 at 12:18 P.M., confirmed that she did throw away a pair of disposable gloves and then touch clean kitchen utensils without washing her hands in between. When DA #284 was asked when staff should be washing their hands, she stated that hands should be washed as needed. Interview with the Kitchen Manger #237 #237 on 04/29/25 at 12:19 P.M. confirmed that staff should be washing their hands after touching the lid of the trash can. Review of the undated policy titled Hand Washing revealed hands and exposed portions of arms should be washed after handling soiled equipment or utensils. Review of the undated policy titled, Low Temperature Door Machine revealed that sanitization solution should be tested three times a day and be 50-100 PPM. Further review of the policy revealed that the dish machine water temperatures should be between 120-140 degrees Fahrenheit. Review of the undated policy titled Food Storage revealed containers for bulk items (flour, sugar, etc.) are to be stored and sealed in a leak proof container with a date and label.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, family interview, and staff interviews, the facility failed to ensure therapeutic rehabilitation services were provided as ordered. This affected one (#366) of one resident reviewed for reviewed for therapy services. Facility census was 65. Findings include Review of the closed medical record for Resident #366 revealed an admission date of 02/19/25 and discharge 03/28/25. Diagnoses included cellulitis, kidney disease, mood disorder, and diabetes. Review of Hospital referral dated 02/18/25 revealed resident needed skilled rehab stay for wounds and therapy (Physical and Occupational). Review of physician orders dated 02/19/25 for Physical/Occupational/Speech therapy (PT/OT/ST) to evaluate and treat. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #366 was cognitively intact with a Brief Interview Mental Status (BIMS) of 13 and was dependant with toileting, substantial /maximum assistance with oral hygiene, bathing, dressing and personal hygiene. Interview on 05/01/25 at 9:52 A.M., with Therapy Director (TD) #229 revealed when Resident #366 admitted , she was seen by Physical Therapy, but was unable to see Occupational Therapy (OT) due to not having staffing. TD #229 confirmed the facility had no Occupational Therapist for evaluations of unskilled residents and revealed they had a staff they brought in only for skilled evaluations. TD #229 revealed they were about to start OT services when resident discharged after hiring a new Occupational Therapist and confirmed resident had an order for PT/OT eval and treat and met criteria and approval to begin OT services once staffing could meet the need. Interview on 05/01/25 at 10:20 A.M., with Regional Nurse #500 confirmed residents should be receiving therapy if admitted for therapy and if an eval is ordered and is needed it should be done. Regional Nurse #500 acknowledged staffing was not a sufficient reason to not provide needed services. Interview on 05/01/25 around 2:00 P.M., with Resident #366's family revealed the resident was not provided the therapy they were promised at admission. This deficiency represents the noncompliance investigated under Complaint Number OH00164520.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, resident interview, staff interview, and review of the arbitration agreement, the facility failed to ensure residents understood the arbitration agreement in a simple manner for residents to understand. This affected three (#4, #10, and #57) of 39 residents who had arbitration. The facility census was 65. Findings include: 1. Review of the medical record for Resident #4 revealed an admission date of 01/15/24. Diagnoses included type two diabetes mellitus (DM II), schizophrenia, and hypertension. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 15. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 15. Review of the arbitration agreement dated 01/16/24 revealed Resident #4 signed the arbitration agreement. Interview on 05/01/25 at 9:01 A.M., with Resident #4 revealed he was not explained what he was signing and wouldn't have signed the arbitration agreement if it was explained to him correctly. Interview on 05/01/25 at 9:16 A.M., with Admissions Director (AD) #309 verified she doesn't explain to residents that they are waiving their right to take the facility to court in a language that they understand. 2. Review of the medical record for Resident #10 revealed an admission date of 01/15/25. Diagnoses included schizophrenia, type two diabetes mellitus (DM II), and mood disorder. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 13. Review of the arbitration agreement dated 01/24/25 revealed Resident #10 signed the arbitration agreement. Interview on 05/01/25 at 9:22 A.M., with Resident #10 revealed she did not recall signing the arbitration agreement and was not explained what she was signing. Resident #10 verified she would have not signed the arbitration agreement. Interview on 05/01/25 at 9:16 A.M., with Admissions Director (AD) #309 verified she doesn't explain to residents that they are waiving their right to take the facility to court in a language that they understand. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the medical record for Resident #57 revealed an admission date of 03/24/25. Diagnoses included type two diabetes mellitus (DM II), generalized anxiety disorder (GAD), and major depressive disorder. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #57 had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 15. Interview on 05/01/25 at 8:20 A.M., with Resident #309 revealed she was not informed that she signed the arbitration agreement or explained what she was signing. Resident #309 stated she would have not signed the arbitration agreement if explained correctly. Interview on 05/01/25 at 9:16 A.M., with Admissions Director (AD) #309 verified she doesn't explain to residents that they are waiving their right to take the facility to court in a language that they understand. Review of the optional arbitration agreement revealed the following: by signing this arbitration agreement, the resident and the facility were waiving the right to a jury trial for any dispute disagreement, controversy, demand, or claim and agree that the arbitrator's decision binds both parties and was final.

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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 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, medical record review, staff interview and review of facility policy, the facility failed to ensure staff performed hand hygiene after providing resident care. This affected two residents (#7 and #266). Additionally, the facility failed to ensure proper disposal of personal protective equipment (PPE) following care provided to Resident #7, who was on enhanced barrier precautions (EBP). This affected two residents (#7 and #266) of two residents reviewed for infection control. The facility census was 65. Findings included: 1. Medical record review for Resident #7 revealed an admission date of 12/30/22. Diagnoses included arteriosclerotic heart disease, schizophrenia, Alzheimer's disease, diabetes, chronic kidney disease, and convulsions. Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/08/25, revealed Resident #7 was severely cognitively impaired. His functional status was setup or clean-up assistance for eating, substantial/maximal assistance for toileting, and supervision or touching assistance for bed mobility and transfers. Resident #7 was always incontinent of bladder and had a colostomy. Review of a physician order dated 03/01/25 revealed Resident #7 was in enhanced barrier precautions (EBP) due to a wound and colostomy. Observation on 04/28/25 at 2:00 P.M. of incontinence care for Resident #7, provided by Certified Nursing Aide (CNA) #230, revealed CNA #230 donned a gown and gloves to provide care. After providing care, Resident #7 asked CNA #230 to get a piece of candy from the drawer next to his bed. While still wearing the gloves and gown used to provide incontinence care, CNA #230 opened the drawer, reached in, and removed a candy bar from the drawer. CNA #230 asked Resident #7 if he wanted her to open the candy bar for him, to which he replied yes. With her gloved hands, CNA #230 opened the candy bar and provided it to Resident #7. Interview with CNA #230 on 04/28/25 at 2:15 P.M. confirmed she was still wearing the soiled gloves from providing incontinence care for Resident #7 and did not perform hand hygiene before touching the resident's drawer and candy bar. Additional observation on 04/30/25 at 11:50 A.M. revealed CNA #230 donned gloves and a gown and assisted Resident #7 out of bed. CNA #230 used her hands to assist the resident up in bed and then assisted him to stand up to the walker. CNA #230 pulled Resident #7's pants up. Before exiting the resident's room, CNA #230 removed her gown and gloves and tucked them under her arm. CNA #230 did not wash her hands. CNA #230 proceeded out of Resident #7's room and entered the room next door. CNA #230 pulled the privacy curtain closed with her unwashed hands. CNA #230 exited the room, with the soiled PPE still tucked under her arm. Interview with CNA #230 on 04/30/25 at 11:55 A.M. confirmed she placed the soiled PPE under her arm, did not perform hand hygiene, entered the room next to Resident #7's, touched the privacy curtain, exited that room and still did not wash her hands. At this time, CNA #230 used hand sanitizer. (continued on next page)

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	366236	A. Building B. Wing	05/01/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #266 revealed an admission date of 01/06/23. Diagnoses included Alzheimer's disease, Parkinson's disease, anxiety disorder, and type two diabetes mellitus (DM II). Review of the quarterly MDS assessment, dated 02/06/25, revealed Resident #266 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of nine. Resident #266 required partial assistance with toileting and transfers, was staff dependent with bathing, and required substantial assistance with dressing. Observation on 04/30/25 at 1:49 P.M. of catheter care provided for Resident #266 by CNA #256 revealed the CNA donned gloves to provide care. After care was completed, while still wearing the gloves used to provide catheter care, CNA #256 touched the bed controller, sheets, and Resident #266's head to rearrange the pillow. Interview on 04/30/25 at 2:14 P.M. with CNA #256 verified she did not remove her soiled gloves or perform hand hygiene before touching Resident #266's head, pillow, and other clean areas in the resident's room. Review of the facility policy titled, Handwashing, dated 10/01/23, revealed hand hygiene was indicated immediately before touching a resident; before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device; after contact with blood, body fluids, or contaminated surfaces; after touching a resident; after touching the resident's environment; before moving from work on a soiled body site to a clean body site on the same resident; and immediately after glove removal.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on medical record review, staff interview and review of facility policy, the facility failed to ensure influenza (flu) and pneumococcal vaccinations were offered to residents and further failed to ensure education on the vaccinations was provided to residents and/or their representatives. This affected one resident (#7) of five residents reviewed for vaccination status. The facility census was 65. Findings include: Review of the medical record for Resident #7 revealed an admission date of 02/19/20. Diagnoses included heart disease, schizophrenia, diabetes, Alzheimer's disease and kidney disease. Review of the Minimum Data Set (MDS) assessment, dated 03/08/25, revealed Resident #7 was severely cognitively impaired. Further review of the medical record revealed no evidence Resident #7 was offered or received the flu or pneumococcal vaccinations or that the resident or resident representative received education on the vaccination. Interview on 05/01/25 at 8:39 A.M. with the Director of Nursing (DON) verified the facility had no evidence of the flu and pneumococcal vaccinations being offered or administered to Resident #7 and further confirmed the facility had no evidence of education provided to the resident or the resident's representative related to the vaccinations. Review of the facility policy titled, Influenza Vaccine, dated 03/22, revealed all residents shall be offered the flu vaccine each year from October to March, unless contraindicated. Review of the facility policy titled, Pneumococcal Vaccine, dated 10/23, revealed all residents shall be offered the pneumococcal vaccine within 30 days of admission unless contraindicated.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on medical record review, staff interview and review of facility policy, the facility failed to ensure COVID-19 vaccines were offered to residents, failed to ensure education was provided related to the vaccination, and further failed to ensure vaccines were administered as consented to. Additionally, the facility failed to ensure COVID-19 vaccination consent forms were thoroughly and accurately completed to reflect resident decisions related to the vaccination. This affected four (#7, #30, #33, and #53) of five residents reviewed for COVID-19 vaccination status. The facility census was 65. Findings include 1. Review of the medical record for Resident #7 revealed an admission date of 02/19/20. Diagnoses included heart disease, schizophrenia, diabetes, Alzheimer's disease and kidney disease. Review of the Minimum Data Set (MDS) assessment, dated 03/08/25, revealed Resident #7 was cognitively impaired. Further review of the medical record revealed no evidence Resident #7 was offered or received the COVID-19 vaccination. Additionally, the medical record revealed no evidence the resident or the resident's representative were offered the vaccination or received education on the COVID-19 vaccination. Interview on 05/01/25 at 8:39 A.M. with the Director of Nursing (DON) confirmed the facility had no evidence Resident #7 was offered or received the COVID-19 vaccination or evidence the resident or resident representative received education on the vaccine. 2. Review of the medical record for Resident #30 revealed an admission date of 08/13/24. Diagnoses included pneumonia, malnutrition, hemiplegia, heart failure, vascular disease, and respiratory failure. Review of the MDS assessment, dated 02/20/25, revealed Resident #30 had moderate cognitive impairment. Review of the COVID-19 vaccination consent form revealed it was signed and consented for on 10/12/24. Review of a physician order dated 11/06/24 revealed the COVID-19 vaccine was ordered for Resident #30. Further review of the medical record revealed no evidence the COVID-19 vaccine was administered to Resident #30, as consented to. Interview on 05/01/25 at 8:39 A.M., with the DON confirmed facility had no evidence Resident #30 received the COVID-19 vaccine. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the medical record for Resident #33 revealed an admission date of 09/19/24. Diagnoses included sepsis, diabetes, and vascular disease. Review of the MDS assessment, dated 03/27/25, revealed Resident #33 was moderately cognitively impaired. Review of the COVID-19 vaccination consent form revealed it was signed and consented to on 10/11/24. Review of the physician orders revealed no evidence the COVID-19 vaccine was ordered for Resident #33. Further review of the medical record revealed no evidence Resident #33 was administered the COVID-19 vaccine, as consented to. Interview on 05/01/25 at 8:39 A.M. with the DON confirmed facility had no evidence Resident #33 received the COVID vaccine. 4. Review of the medical record for Resident #53 revealed an admission date of 08/13/24. Diagnoses included dementia, malnutrition, depression, emphysema and syncope. Review of the MDS assessment, dated 02/20/25, revealed Resident #53 had moderate cognitive impairment. Review of COVID-19 vaccination consent form revealed it was signed, but had no date and none of the boxes were checked to indicate whether the vaccination was consented to or declined. Further review of the medical record revealed no evidence Resident #53 was administered the COVID-19 vaccination. Interviews on 04/30/25 from 4:47 P.M. to 6:49 P.M. with Regional Nurse (RN) #500 and RN #508 revealed COVID-19 vaccination consents should be dated to verify when they were offered and ensure timeliness. RN #500 and RN #508 verified Resident #53's vaccination consent was undated and did not indicate the resident or resident representative's decision on receiving the vaccination. Review of the facility policy titled, Coronavirus Disease (COVID-19) - Vaccination of Residents, dated 05/23, revealed residents shall be offered the COVID-19 vaccine. The vaccination administration shall be documented in the medical record.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, staff interview, medical record review and review of facility policy, the facility failed to ensure resident bathrooms were free from odors for five (#7, #18, #37, #51, and #60) five residents reviewed for clean and sanitary bathrooms. Additionally, the facility failed to ensure the corridors were free from pervasive odors. This affected all residents except for 16 residents (#2, #5, #6, #8, #14, #22, #23, #33, #39, #40, #41, #43, #52, #56, #58, #62) identified as living on the rehabilitation unit. The facility census was 65. Findings included: 1. Medical record review for Resident #7 revealed an admission date of 12/30/22. Diagnoses included arteriosclerotic heart disease, schizophrenia, Alzheimer's disease, diabetes, chronic kidney disease, and convulsions. Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/08/25, revealed Resident #7 was severely cognitively impaired. His functional status was setup or clean-up assistance for eating, substantial/maximal assistance for toileting, and supervision or touching assistance for bed mobility and transfers. He was always incontinent of bladder and the resident had a colostomy. Resident #7 had wandering behaviors. Observation of Resident #7's bathroom on 05/01/25 at 12:45 P.M. revealed there was a strong urine odor, with no indication as to the source of the foul odor. Interview with the Maintenance Director (MD) #300 on 05/01/25 at 1:00 P.M. confirmed the strong urine odor in Resident #7's bathroom and further verified the source of the odor was unknown. 2. Observations of the facility on 04/28/25 at 9:00 A.M., 04/30/25 at 9:08 A.M. and on 05/01/25 at 6:30 A.M. revealed a strong urine and body odor throughout all of the halls, except for the rehabilitation unit. Interview with Certified Nursing Assistant (CNA) #230 on 04/28/35 at 9:00 A.M. confirmed the halls had a foul odor. Interview with CNA #254 and CNA #230 on 04/30/25 at 9:10 A.M. confirmed there was a foul odor in the facility. CNA #230 and CNA #254 stated they did not know how to get rid of the odor, adding they used a spray but some of the residents did not bathe and they believed that contributed to the odors. 3. Review of the medical record for Resident #51 revealed an admission date of 02/07/25. Diagnoses included shortness of breath, diabetes, and heart failure. Review of the MDS assessment, dated 02/14/25, revealed Resident #51 was cognitively intact and required supervision or touching assistance with toileting. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record for Resident #18 revealed an admission date of 05/07/24. Diagnoses included dementia, Alzheimer's disease, and cognitive communication deficit. Review of the MDS assessment, dated 02/09/25, revealed Resident #18 was rarely/never understood and required supervision or touching assistance with toileting. Review of the medical record for Resident #60 revealed an admission date of 04/01/24. Diagnoses included ataxia, dyspnea, edema and weakness. Review of the MDS assessment, dated 04/10/25, revealed Resident #60 was cognitively intact and required partial/moderate assistance with toileting. Review of the medical record for Resident #37 revealed an admission date of 12/31/20. Diagnoses included myocardial infarction, hemiplegia and hemiparesis, cerebral infarct, heart disease, and vascular dementia. Review of the MDS assessment, dated 04/20/25, revealed Resident #37 was severely cognitively impaired and required partial/moderate assistance for toileting. Observation on 04/28/25 at 10:20 A.M. revealed the shared bathroom for Resident #18, Resident #37, Resident #51 and Resident #60 had a strong, pungent urine odor and a sticky residue on the floor. Interview on 04/28/25 at 1:10 P.M. and interview on 04/28/25 at 1:10 P.M. with MD #300 confirmed the bathroom had a strong, foul urine odor and a sticky residue on the floor. Review of the facility policy titled, Homelike Environment, dated 02/21, revealed residents shall be provided a clean and comfortable environment. The facility shall provide a homelike setting that was clean with pleasant neutral scents. This deficiency represents the noncompliance investigated under Complaint Numbers OH00164520 and OH00164238.