| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 366250 | A. Building<br>B. Wing | 03/09/2026 |

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| Kimes Nursing & Rehab Ctr | 75 Kimes Lane<br>Athens, OH 45701 |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure a resident's change in condition was timely identified, properly correlated to a suspected medication error, and promptly reported to the physician for necessary medical intervention. This affected one resident (#42) of three residents reviewed for medication administration errors. Findings include:<br><br>Review of Resident #42's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included dementia, neurocognitive disorders with Lewy Bodies, unspecified mood disorder, major depressive disorder, anxiety disorder, congestive heart failure, hypertension, cirrhosis of the liver, muscle weakness, lack of coordination, difficulty walking, and insomnia.<br><br>Review of Resident #42's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and was cognitively intact. He was not known to display any behaviors and was not indicated to have received any anti-anxiety medications or opioids.<br><br>Review of Resident #42's active physician's orders, as of 01/30/26, revealed the resident had orders to receive the following medications: Abilify (an anti-psychotic sometimes used as conjunctive therapy for major depression not receptive to antidepressants) 2 mg po every (q) morning (am) for depression, Aspirin Enteric Coated 81 mg po q am, Atorvastatin (cholesterol lowering medication) 80 mg po q night at bedtime (hs), Vitamin D 2,000 units po q am, Plavix (an antiplatelet) 75 mg po q am for blood clot prevention, Aricept 5 mg po q hs for dementia, Fluoxetine (an antidepressant) 30 mg po q am for depression, Lactulose 30 milliliters (ml) po three times daily, Magnesium Oxide 400 mg po q am, Melatonin 10 mg po q hs for insomnia, Remeron 7.5 mg po q hs for appetite stimulant, Potassium Chloride 20 milliequivalents (meq) po twice a day for hypokalemia, Sennosides (constipation medication) 8.6 mg (two tablets) po twice a day for constipation, and Tamsulosin HCL 0.4 mg po q hs for an enlarged prostate. His medications ordered on an as needed (prn) basis included Acetaminophen for general discomfort, artificial tears prn for dry eyes, Mucinex prn for congestion, and Zofran prn for nausea. He was not ordered to receive a benzodiazepine for anxiety or a narcotic pain medication for pain.<br><br>Review of Resident #42's nurses' progress notes revealed a nurse's note by Agency Nurse LPN #100 dated 01/31/26 at 1:51 A.M. indicated at approximately 8:00 P.M. the nurse checked on the resident and administered his medications to him. The resident complained of feeling tired from a room change that occurred earlier that day. The nurse helped prepare the resident for bed. The nurse's note further indicated at approximately 8:53 P.M. she went to do rounds on the resident, and his wife was at his bedside. The wife said he (Resident #42) was sleeping and hadn't woken up during the time she had been there. The nurse attempted to wake the resident, and he reacted to touch but was lethargic. The resident was able to grasp her hands and push his feet against her hands when requested showing<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | the ability to follow command. The nurse obtained his vital signs, and all were within normal limits. His blood pressure was 108/72, heart rate was 68 beats per minute, his respiration rate was 17/ minute, and his temperature was 98.1 degrees Fahrenheit (F.). The wife indicated that she would just come back tomorrow and to let the resident rest. This nurse went back to check on the resident throughout the night, and he seemed to be sleeping peacefully. He was still reactive to touch but remained lethargic. At approximately 1:15 A.M., the nurse went to check on the resident again and he was more lethargic than previously noted throughout the night. The resident wasn't responding to stimuli. The nurse attempted a sternal rub (movement using the knuckles of your hand in an up and down motion over the sternum to elicit a response) on the resident with no reaction. The nurse obtained another set of vital signs and noted his blood pressure to be 96/62 mmHg (hypotensive) and a radial pulse rate of 62/ minute. His oxygen saturation was 92% on room air (lower side of normal). The on-call physician was contacted, and an order was received to transport the resident to the emergency department (ED) for an evaluation. EMS was contacted about the need for transport and arrived at the facility at approximately 1:45 A.M. The nurse gave report to EMS personnel upon their arrival.<br><br>Review of Resident #42's Skilled Nursing Facility/ Nursing Facility to Hospital Transfer Form dated 01/31/26 at 1:45 A.M. completed by Agency Nurse #100 revealed Resident #42's reason for transfer was an altered mental status. He was also indicated to have a blood pressure reading of 96/62 mmHg. His relevant diagnoses listed included dementia and difficulty in walking.<br><br>Review of Resident #42's EMS Run Report dated 01/31/26 revealed EMS responded to the facility after a call was received at 1:26 A.M. for an unconscious or fainting individual. They were on-site at 1:37 A.M. The chief complaint was bradycardia and a secondary complaint was hypotension. The resident was indicated to have a significant medical history for congestive heart failure, dementia, hypertension, cirrhosis of the liver, anxiety, tremors, myocardial infarction (MI), and encephalopathy. His current medications included Cholecalciferol (Vitamin D), Fluoxetine, Acetaminophen, Plavix, Tamsulosin, Lactulose, Donepezil, and Melatonin. He was indicated to be in moderate distress and there were no reported factors of drug use affecting care. The resident was unresponsive with a primary impression of unconsciousness. He responded to painful stimuli. His Glascow coma scale (a 3-15 point clinical tool used to objectively assess the consciousness level of an individual by measuring eye opening, verbal response, and motor response) was 7 (15 = fully awake, 13-15 = mild brain injury, 9-12 =moderate brain injury, 3-8 + severe brain injury) with eye opening to painful stimuli, withdrawal from pain, and no verbal response. His vital signs revealed hypotension with a blood pressure of 80/52 mmHg. His blood sugar was 133 milligrams/ deciliter (mg/ dl). He received 4 mg of Narcan (medication used to reverse the effect of a drug overdose) intranasally, due to how he presented with pinpoint pupils. Intravenous (IV) therapy was initiated into his left forearm for administration of 0.9 Normal Saline. The resident was administered an additional 2 mg of Narcan IV and subsequently 1 mg of Atropine (medication used to treat a slow heart rate) IV. Upon arrival at the hospital, the resident's condition was noted to have improved, but he was still unresponsive.<br><br>Review of the facility's incident/ accident log for the past six months revealed Resident #42's incident occurring on 01/31/26 was included under other incidents. An interview with the facility's Director of Nursing (DON) on 02/25/26 at 2:54 P.M. to clarify what other incidents involved revealed the other incident that was documented as having occurred on 01/31/26 at 1:15 A.M. pertained to the resident's transfer out to the hospital for unresponsiveness. She stated the resident reportedly had a room change that occurred earlier that day and he became tired/ weak from that. She was asked if the resident's symptoms were possible related to receiving the wrong medication, as was an allegation in the complaint, and she indicated that it was possibly medication related. She indicated (continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | they did an investigation into the incident but did not feel she was able to determine that was the cause of his change in condition. She was asked to provide that investigation for review.<br><br>Review of the facility's investigation of the incident involving Resident #42's change in condition occurring on 01/31/26 at 1:15A.M. revealed it included incident statements she received from several employees, including an agency nurse, who all worked on the evening of 01/30/26 and into the morning hours of 01/31/26. The investigation file also included a copy of the hospital records pertaining to Resident #42, medication administration records (MAR's) for Resident #15 and #42, and a performance improvement plan (PIP).<br><br>Review of an incident statement from Agency Nurse #100 obtained by the facility's DON dated 01/31/26 at 5:10 P.M. revealed the nurse informed the DON that she went into Resident #42's room to give him his evening/ bedtime medications, when the resident reported he was tired. After giving him his medications, she helped the resident put his feet up in bed and he laid down. The nurse did not bother him again until his wife came to visit and informed her the resident did not wake up during her visit. The wife put her cold hands on the resident, but he still did not wake up. That was when the nurse reported she had become a little concerned. The resident was still alert at the time and could open his eyes. He was also able to squeeze her hands and everything. She just figured he was tired, so she left him alone but kept going back and checking on him. When he did not respond to verbal commands to squeeze her hand, or her shaking him, or to a sternal rub that was when she called the physician. The wife reportedly arrived at the facility around 8:53 P.M. The nurse did not know the wife was there until she went back to the room to inform the roommate (Resident #15) that he had already been given his pain medication. Resident #15 had complained to an aide earlier that he was still having pain and said his pain medications did not work. An aide had previously told him he had already got his medications, but the nurse was just going back to tell him the same. That was when the nurse said she saw Resident #42's wife and was told about the resident not waking up during her visit. The nurse assessed the resident, but the resident acted like he was just sleepy. She got another nurse (LPN #135) to check him, and they both just thought the resident was sleepy from moving earlier that day. She did not think anything about it until he stopped responding later in the evening. She was asked by the DON if she remembered when she originally went into the resident's room and indicated it was at the beginning of her shift, sometime around 8:00 P.M., when she gave him his medications and the resident told her he was tired. She denied she noticed anything else about the resident at that time. The DON then asked the nurse if the resident got worse and became more lethargic as the night went on. The nurse responded that it was correct. Once he was like that, she called the provider because the resident was a full code. The wife seen that the resident was not awake after they tried to get him to drink his milkshake. The nurse reported the wife was like oh well, she would just come back tomorrow telling the staff to just let him rest. The nurse then left the resident's room but would just return routinely to check on him. He was still able to respond, at least a little bit, during her follow-up checks. Once he stopped responding, she called the provider. His vital signs remained around 108 (not clear what vital sign she was referencing). Since the nurse did not really know the resident, she asked the wife when she was there if the resident normally slept that deep. The wife responded sometimes, not really, and the nurse did not feel the wife seemed concerned and that he was just in a deep sleep. The nurse was asked by the DON how she prepared her medications for that room. The nurse admitted she prepared them at the same time pulling them both out and popping them both into medication cups that she wrote their names on. She crushed Resident #42's pills and mixed them with pudding before taking them to him. She then went back and gave his roommate (Resident #15) his pills whole. The DON asked the nurse if the roommate said anything about getting the wrong medications. The nurse admitted the room was dark when she gave Resident #15 his medications, but he took them. 20 minutes later he was complaining to his aide (Certified Nursing Assistant #150) that<br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | he didn't feel like he got his medications because he could normally tell 10 minutes after he took them and that time, he did not feel that way.<br><br>Review of an incident statement from LPN #135 obtained by the facility's DON dated 01/31/26 at 5:19 P.M. revealed she was asked by Agency Nurse #100 to come back to Resident #42's room to check on him. When she got back to the room, the resident's wife was there. The nurse reported she did not work with Resident #42 that much, but something just seemed off. His vital signs were stable but he had just moved and they all thought maybe it was just the move or something like that. The aide (CNA #150) continued to do his rounds and the other nurse (Agency Nurse #100) went back and checked on him every once in a while. The staff came and got her a second time to check on the resident. That time she said she was like somethings just not right. His vitals were low, but they were still you know he was, she just had a bad feeling so she looked up his code status and he was a full code. She told the other nurse (Agency Nurse #100) he was a full code and he needed to go out because the resident was not even like he was the first time. She was only able to get the resident to kind of squeeze her hand, after a little time, and he fluttered his eyes and moved his feet well the first time but when they went in prior to calling the squad he would not do any of that. She told the other nurse there was something wrong with him and he needed to go out. She was asked if there was anything else she remembered. She told the DON the roommate was saying well she (agency nurse) gave him (Resident #42) his (Resident #15's) pills. The other nurse (agency nurse) responded and told her she swore that she did not. She replied she was not there, so she did not know but they (EMS) did give him (Resident #42) Narcan. His pupils were pinpoint, but he had no response to the Narcan. The EMS only administered one dose of the Narcan while there. She was not sure if they gave anymore after they left. The EMS did say it could take up to 15 minutes for a response. Even after he was loaded in the truck, the resident was still not responding. She then denied she heard anything directly from the roommate about his medications. What she heard about Resident #42 getting Resident #15's medications came from the nurse (Agency Nurse #100).<br><br>Review of an incident statement from Certified Nursing Assistant (CNA) #150 obtained by the facility's DON dated 01/31/26 at 5:30 P.M. revealed Resident #42 was acting himself at first mumbling. He did not seem out of his normal and he was usually tired. It was usually hard to understand the resident but later he became more lethargic. His family brought him McDonalds and the resident seemed like he was coming out of it, or so they thought. His vitals were fine. Around midnight, he started getting worse. The resident was not interacting with him as much. He denied he got anything in report about Resident #42, or that there was a resident that they really needed to watch. He was asked by the DON if there seemed to be anything abnormal for the resident when he first arrived on shift. He stated he could not tell anything different at first, but the resident took a drastic turn after his wife left and he thought that was sometime between or around midnight.<br><br>Review of Resident #42's MAR's for January 2026 that was included in the facility's investigation file revealed Resident #42 should have been given the following medications ordered at bedtime on 01/30/26: Atorvastatin 80 mg po, Donepezil HCL 5 mg po, Melatonin 10 mg po, Remeron 7.5 mg po, Tamsulosin HCL 0.4 mg po, Potassium Chloride 20 meq po, Senna 8.6 mg two tablets po, and Lactulose 30 ml po. The nurse administering those medications was identified as being Agency Nurse #100. The medications given to the resident was his 6:00 P.M. medications, also indicated to be his hs medications. A medication administration audit report showed that he was documented as having received those medications on 01/30/26 at 8:44 P.M.<br><br>Review of Resident #42's roommate's (Resident #15's) MAR for January 2026 revealed Resident #15 was scheduled to receive the following medications at bedtime on 01/30/26: Atorvastatin 40 mg po, (continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Xanax 2 mg po, Eliquis 5 mg po, Sinemet 10-100 mg po, Gabepentin 800 mg po, and Percocet 10-325 mg po. The medications were signed off as having been given by Agency Nurse #100. A medication administration audit report showed that he was documented as having received those medications on 01/30/26 at 8:23 P.M. The controlled drug record for the Oxycodone- Acetaminophen (Percocet) 10-325 mg tablet and the Xanax 2 mg tablet were signed out of the controlled medication box on 01/30/26 at 8:00 P.M. (23 minutes prior to the controlled medication being documented as having been administered).<br><br>Review of Resident #42's hospital records that were included in the facility's investigation file revealed they included Emergency Department (ED) notes, a hospital History and Physical (H&P), and a Discharge Summary from a local hospital. There were additional records from another hospital that Resident #42 had been transferred to.<br><br>Review of Resident #42's ED Triage Note dated 01/31/26 at 2:31 A.M. revealed the resident arrived at the hospital from the nursing facility, after being found unresponsive. Per the EMS, the resident was responding to pain on arrival and had pinpoint pupils. His blood pressure was 80/50 (low) and heart rate was 45 beats per minute (bpm). He was administered at total of 6 mg of Narcan and 1 mg of Atropine.<br><br>Review of an ED Provider Note dated 01/31/26 at 4:51 A.M. revealed Resident #42's chief complaint was hypotension, bradycardia, and unresponsiveness. His reported last known well was around 8:00 P.M. (approximately six hours prior to arrival). The resident was poorly responsive, but did have a gag reflex, and had some arousability to a sternal rub. He was spontaneously breathing with reasonable rate. EMS reported initial miotic pupils. Narcan was tried with some pupillary response and possibly some initial response in terms of arousability but not maintained and not responsive to additional doses. He was supported with low dose pressor therapy for borderline low pressures. A central line was placed for ICU stability. His social history indicated he was never known to use drugs. Pupils were equal at 3 millimeters, after multiple doses of Narcan (per EMS was reported to be miotic previously). Clinical impression was acute encephalopathy, unresponsiveness, abnormal CT of lung, sinus bradycardia. Other known diagnoses in his history included congestive heart failure (CHF), dementia with Lewy Bodies, and cirrhosis of the liver. He was released from the ED and admitted to the hospital's ICU. A Urine Drug Screen collected on 01/31/26 at 5:03 A.M. revealed the resident tested positive for Benzodiazepines (classification of a type of antianxiety medication to include Xanax) and Oxycodone (neither of which the resident had an order to receive and was consistent with what was ordered for his roommate at hs.)<br><br>Review of Resident #42's hospital H&P dated 01/31/26 at 5:52 A.M. revealed the resident presented from the nursing home with complaints of an altered mental status and unresponsiveness. He was admitted to the hospital ICU with risk variables including conventional mechanical ventilation, acute respiratory failure , pneumonia, and dementia. His hospital diagnoses included acute hypoxic (low oxygen levels in the blood) respiratory failure and multifocal pneumonia. He was mildly hypoxic requiring supplemental oxygen upon arrival, initially maintaining airway, however he had progressive respiratory decline necessitating endotracheal intubation (plastic tube inserted through the mouth and down the throat for airway access) to maintain airway patency. He was also diagnosed as having shock. He did not meet sepsis criteria at that time but was having persistent hypotension despite IV fluids prompting initiation of Norepinephrine. Under his diagnosis of unresponsiveness, the resident presented from nursing home with concerns of unresponsiveness status with pinpoint pupils, B/P of 80/50 and a HR of 45. He received Narcan with some improvement in mentation. CT of the head was negative for any acute findings. Medication reconciliation without clear etiology, possible Remeron<br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | mediated although unclear of timing of medications/ ingestion quantity. A lumbar puncture (LP) was attempted in ED, dry tap. During the hospital admission, when the CT scan was being performed, the resident became grossly bradycardic and there was concern for airway loss. He had to be transported back to the ED and subsequently intubated for airway protection and critical care management.<br><br>Review of Resident #42's hospital Discharge summary dated [DATE] at 10:56 A.M. revealed the clinical summary of the resident's condition indicated he was found unresponsive in the nursing home with a downtime suspected to be around three hours. Per his wife, the resident was drowsy/ sleepy around 9:00 P.M., prior to the day of admission into the hospital. He was found unresponsive at around 11:00 P.M. by the staff at the nursing facility. His wife suspected the resident might have been given the wrong medications, as per his roommate, including opioids and Gabapentin. Upon arrival to the ED, the resident was hypoxic and unable to protect his airway, hence he had to be intubated for respiratory support. Urine Drug Screen (UDS) was notably positive for Benzodiazepines, which was not listed on the resident's medication list. There was concern for possible toxic metabolic encephalopathy, as there were concerns of opioid and Gabapentin intake that was noted on the UDS. He was discharged from the hospital and transferred to another hospital in Columbus, Ohio. Discharge diagnoses included acute hypoxic respiratory failure, acute encephalopathy- metabolic versus toxic versus ischemic versus epileptic, persistent acute on chronic bradycardia, and distributive versus cardiogenic shock.<br><br>Review of Resident #42's hospital records from the hospital he was transferred to in Columbus, Ohio included an Attending Critical Care note from a pulmonologist dated 02/01/26 at 4:46 P.M. It revealed the resident's events from the past 12-24 hours were reviewed and discussed on rounds on 02/01/26 with the multidisciplinary team. The note indicated there was documented speculation from his family that they were concerned that the resident may have gotten the wrong medications and could have gotten his roommate's medication. There was no medical documentation from the facility to corroborate that, however, he did have Oxycodone on his toxicology screen.<br><br>Review of Resident #42's hospital Discharge Summary from the hospital located in Columbus, Ohio dated 02/05/26 at 3:00 P.M. revealed the resident was transferred to their hospital on [DATE] for further evaluation. The reason for the transfer was to obtain an MRI, as the previous hospital was not able to accommodate a resident with a ventilator to use their MRI machine. He was found to have a reduced ejection fraction on a transthoracic echocardiogram. His diagnoses included acute metabolic encephalopathy, likely multi-factorial on baseline Lewy Body dementia, complicated by hypoperfusion vs. polypharmacy vs. anoxic brain injury in setting of prolonged down time and hypoglycemia. The resident was reportedly given his roommate's medications (opioids and Gabapentin) but unable to confirm that. He also had acute hypoxic respiratory failure and was intubated on 01/31/26 for airway compromise in the setting of encephalopathy. He was extubated (breathing tube removed) on 02/02/26. His right lower lobe lung was noted to have peri bronchial thickening consistent with chronic bronchitis. His infectious workup was negative. His diagnosis of bradycardia had an unclear etiology. He was not on any heart rate reducing medications, but had a reported baseline HR in the 50's. With his diagnosis of undifferentiated shock, sepsis was initially suspected from a pulmonary source but was ruled out. The shock was possibly of a cardiogenic source.<br><br>On 02/26/26 at 9:20 A.M., an interview with the DON revealed she did not feel she could substantiate that a medication error had occurred with Resident #42 on 01/30/26 because she did not feel she had the evidence to support such. The agency nurse denied that she had given the resident the wrong medication and she could not be certain Resident #42 did not received a benzodiazepine or opioid from another source. She confirmed Resident #42's urine drug screen collected on 01/31/26, while in the (continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | hospital, showed Benzodiazepines and Oxycodone were detected in his system and the resident was not ordered to receive those medications. She further confirmed Resident #42's roommate (Resident #15) was scheduled to receive Xanax and Oxycodone at bedtime, that supported his concerns that the agency nurse working that night mixed up their medications.<br><br>On 02/26/26 at 12:55 P.M., an interview with Resident #15 revealed he recalled the evening of 01/30/26, when his former roommate (Resident #42) had a change in condition. He was having a conversation with Resident #42, at around 8:00 P.M., when they both received their medications. The nurse brought medication into his room giving Resident #42 his medication first and then gave him his medication. He stated he had been given his roommate's medications, and his roommate was given his. He denied that he had seen the pills he took before putting them in his mouth but knew they were not his. He could tell there were more little pills in what was given to him than he normally took, and he noticed the large Gabapentin he took at bedtime was not one of the ones he put in his mouth. He described the Gabapentin as being a large pill and it was difficult for him to swallow. He was not given any pills that large that evening, so he knew they were not his. He could also tell when he received his Oxycodone, as it had a bitter taste, and he did not notice a bitter taste that night. He was also able to tell within 10 or 15 minutes that he got his pills, as he typically had a different feeling after taking them, and that night he did not. He questioned the nurse if he had been given the right medications, as his pain was not relieved after taking the medications, and it normally was soon after taking them. He stated the nurse denied that he had been given the wrong medications. It was around that time when he questioned the staff that his roommate was out of it and could not be wakened. He recalled it was about 10 minutes after his roommate received his pills that the resident was out of it and his wife came in to visit. The wife put her cold hands on his neck and the resident did not respond. He claimed the resident was very lethargic making abnormal sounds and he was like a zombie. They could barely arouse him. He told the staff that they gave Resident #42 his (Resident #15's) medications and that was why he was out of it. He heard one of the nurses (not the nurse administering the medications) tell the other that they did not have any Narcan in the facility. He claimed he had suggested they call 911 because they would have Narcan and the resident needed it for a drug overdose. He confirmed he was to receive Xanax, Gabapentin, and Percocet that evening, which would be hard on someone that did not normally take those medications. He asked Resident #42's wife when she was there if the resident was on any of those medications. The wife denied that he was. He confirmed he was the one who informed the wife that he believed Resident #42 was given his medications. He reported there was a significant change in his roommate's condition, after he received the medication. He felt they should have called the squad sooner than they did. They just left him lying there for about six hours before they finally called the squad. He had heard his roommate was put on life support after going to the hospital. He denied anyone from the facility had assessed him or did any type of investigation into his reports of his medications being mixed up with his roommate's. He would have liked to know what he possibly received by mistake, as he had known allergies to certain medications.<br><br>On 02/26/26 at 2:54 P.M., an interview with Agency Nurse #100 confirmed she was the nurse that worked the evening of 01/30/26, on Resident #42's hall. She recalled the resident having a change in his condition that night requiring him to be transferred to the hospital. She further confirmed it was her that administered medications to Resident #42 and his roommate (Resident #15) that night at bedtime. She could not recall when the medications were administered but stated she charted it, so it should have been documented when they were given. She suspected it was sometime around 8:00 P.M. She reported she had taken back Resident #42's medications first, and then took back Resident #15's. She denied she took both residents their medications back to their room at the same time. She initially could not recall if she prepared the two residents' medications at the same time. Her incident (continued on next page) |

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|---|---|---|---|
| | 366250 | A. Building<br>B. Wing | 03/09/2026 |

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| Kimes Nursing & Rehab Ctr | 75 Kimes Lane<br>Athens, OH 45701 |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | statement she provided to the DON was reviewed with her and it was noted that she did admit to preparing both residents' medications at the same time. She confirmed she did recall writing the residents' names on the medication cups when preparing the medications, so it sounded right that she prepared them at around the same time before passing the medications in that room. She popped the pills out of the blister cards and placed them into the cup with that resident's name on it. She did not feel she mixed up the two residents' medications when popping the medications into the medication cup but stated it was possible that she could have popped them into the wrong cup or grabbed the wrong cup when crushing the medications to be given to Resident #42. She indicated, if she did do that, it was not intentional. She was asked how she identified the residents before giving them their medications. She stated she could not recall the resident's name now, but she asked him at the time if he was so and so and he said yes. She described the resident as being alert, but sleepy at that time. She assisted him with putting his feet u |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of a grievance investigation, and interviews, the facility failed to ensure allegations of misappropriation were reported. This affected one resident (#10) of one resident reviewed for misappropriation. The facility census was 59. Findings include:Record review revealed Resident #10 was admitted to the facility on [DATE] with diagnoses including muscle weakness and hypertension.Review of the resident's care plan revealed no documented evidence of Resident #10 having impaired cognition or behaviors including making false allegations.Review of a minimum data set (MDS) assessment dated [DATE] revealed Resident #10's cognition remained intact and she had no behaviors.Review of a grievance report dated 02/24/26 revealed on the afternoon of 02/24/26, Resident #10's son reported he dropped off five lottery tickets to Resident #10 on 02/22/26, he was not able to come back on 02/23/26, so he came back to the facility on [DATE]. When he arrived to the facility, Resident #10 reported out of the five tickets he had dropped off, there was only one winner for $250 which was now missing. The other four lottery tickets were still there but were not [NAME]. The resident's son stated he searched the room, dressers, drawers, and trashcan but was not able to locate the ticket. Social Worker (SW) #176 went to the resident's room and helped search but the ticket was not located. Resident #10 was interviewed and agreed with the issue her son had presented. The investigation process was then started. On 02/25/26, the room was searched again with no luck. Resident #10 was interviewed and on 02/26/26, staff who worked the hall from 02/22/26-02/24/26 were interviewed. In Resident #10's interview, she stated her son brought in scratch offs tickets on Sunday, there was a winner for $250 and one ticket came up missing some time on Monday but she couldn't remember. Resident #10 stated the last time she saw the winning ticket was Monday morning. She did not throw the ticket in the trash and she did not witness someone else throw it away. Certified Nursing Assistant (CNA) #116 and Licensed Practical Nurse (LPN) #160 had no knowledge of Resident #10 receiving lottery tickets. CNA #155 saw some tickets on Resident #10's bedside table on Monday morning but had no idea if any were [NAME] and resident did not voice concerns about a missing ticket. CNA #163 saw lottery tickets on Sunday night but could not recall how many, Registered Nurse (RN) #147 saw lottery tickets on Sunday but couldn't recall how many, two agency nurses and CNA #150 did not answer the phone when called to be interviewed, Assistant Director of Nursing (ADON) #108 saw lottery tickets on Monday evening but couldn't recall how many, RN #114 saw lottery tickets on Tuesday morning because she always has them on her table but could not recall how many, and CNA #121 saw lottery tickets on Monday but could not recall the amount, but was told by Resident #10 one ticket was a winner and we celebrated her win then on Tuesday Resident #10 reported the ticket missing.Interview on 03/02/26 at 4:32 P.M. with SW #176 revealed Resident #10's son came to her on 02/24/26 and stated he dropped off lottery tickets on Sunday, couldn't come in on Monday, so came in Tuesday to pick up the lottery tickets. Resident #10 had told him she won $250 on a lottery ticket but did not know where it went. SW #176 stated resident said it could've gone in the trash or another resident could've taken it. SW #176 stated she asked if the resident threw away the ticket, if she saw another resident take it or if she saw a staff take it, and resident answered no to all three. SW #176 stated the investigation was ongoing and was reported to the lottery commission and police department. SW #176 stated she was told since the five lottery tickets came off the same roll, the commission would be able to determine if or when it gets cashed and where to determine who cashed it.Interview on 03/03/26 at 9:34 A.M. with Resident #10 revealed her son brought her in lottery tickets, either four or five. Resident #10 stated she scratched off a winner for $250. She left her room to go to an activity or something and left the tickets on her bedside table. Resident #10 stated when she came back to her room she hadn't noticed the ticket was missing but then she noticed it was missing later and told everyone about it. Resident #10 stated she<br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | did not know what happened and they looked everywhere for it. Resident #10 stated she does not want to accuse anybody but someone had to have taken it. Resident #10 stated the facility did not get her a lockbox or new tickets.Follow-up interview on 03/03/26 at 1:24 P.M. with SW #176 revealed an allegation of abuse or misappropriation would be reported to the state by either the Administrator or Director of Nursing (DON).Interview on 03/03/26 at 1:29 P.M. with the Administrator revealed he was informed by the social worker (SW #176) Resident #10's son filed a grievance about a missing lottery ticket which had won money so he instructed her to start an investigation. The Administrator stated if a lottery ticket winning $250 went missing or was alleged to be missing, it would be allegation of misappropriation and should be reported to the state. The Administrator stated he was not sure why the allegation was not reported to the state but he just started working at the facility last week and he did not have the access to report. The Administrator stated allegations of misappropriation should be reported immediately and he believed he was responsible for reporting but he was not sure because in other buildings it was social services responsibility.Interview on 03/03/26 at 1:38 P.M. with the DON revealed the missing lottery ticket situation could be considered potential misappropriation which is why an investigation was being completed to determine what happened to it. The DON stated allegations of misappropriation are reported to the state immediately upon suspicion or discovery. The DON confirmed she had not reported the allegation and had not been told about it until Thursday or Friday the week it happened.Review of a policy titled Abuse Investigation and Reporting dated 12/2016 revealed all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source shall be promptly reported to local, state and federal agencies as defined by current regulations and thoroughly investigated by the facility management. Allegations should be reported within two hours.This deficiency represents an incidental finding of non-compliance investigated under Complaint Number 2790007. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interview, the facility failed to ensure residents who were not able to carry out of activities of daily living independently were provided with showers. This affected three residents (#35, #53, and #62) of five residents reviewed for showers. The facility census was 59. Findings include:1.Record review revealed Resident #35 was admitted to the facility on [DATE] with diagnoses including dementia and muscle weakness.Review of a care plan dated 08/27/25 revealed Resident #35 required assistance with self-care, activities of daily living (ADLs), and mobility related to dementia, weakness, diabetes, impaired mobility, and use of an assistive device. The goal was to continue to have needs met on a daily basis through the review date; remaining clean, dry, dressed, groomed, and free of odors. Interventions included but were not limited to showering assist: dependent with one helper.Review of a minimum data set (MDS) assessment completed on 11/18/25 revealed Resident #35 had no behaviors and required maximum assistance of one staff for bathing.Review of a shower schedule revealed Resident #35 was scheduled to receive showers on Mondays and Fridays on dayshift.Review of showers revealed Resident #35 did not receive a shower on 02/20/26 or 02/27/26.2.Record review revealed Resident #53 was admitted to the facility on [DATE] with diagnoses including hypertension and cancer.Review of a care plan dated 08/15/25 revealed Resident #53 required assistance with self-care, ADLs, and mobility related to pain, disease process, limited mobility, limited range of motion, and weakness. The goal was to maintain current level of function in ADLs throughout the review period. Interventions included but were not limited to dependent for bathing/showering.Review of an MDS dated [DATE] revealed Resident #53 refused care four to six days through the review period and was dependent on staff for bathing.Review of the shower schedule revealed Resident #53 was scheduled to receive showers on Tuesday and Friday dayshift.Review of showers revealed Resident #53 did not receive showers on 12/26/25 or 12/30/25.3.Record review revealed Resident #62 was admitted to the facility on [DATE] with diagnoses including hypertension and osteoarthritis.Review of a care plan dated 10/13/25 revealed Resident #62 required assistance with self-care, ADLS, and mobility related to impaired mobility, weakness, cognitive deficits, and pain. The goal was to minimize risks for decline through review date and continue to have needs met on a daily basis through the review date. Interventions included but were not limited to assist as needed with shower twice weekly or per resident preference, and partial assist with showers.Review of an MDS dated [DATE] revealed Resident #62 had no behaviors and required moderate assistance for bathing/showering.Review of a shower schedule revealed Resident #62 was scheduled to receive showers on Tuesday and Friday nightshift.Review of showers revealed Resident #62 did not receive a shower on 10/21/25, 11/06/25, 11/13/25, 11/25/25, and 11/28/25.Interview on 03/04/26 at 1:10 P.M. with the Assistant Director of Nursing (ADON) confirmed Residents #35, #53, and #62 were not provided personal care services, showers, as scheduled. The ADON stated there would be no other documentation to prove whether or not residents received their showers.This deficiency represents non-compliance investigated under Complaint Number 2722441. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure wound care treatments were completed as ordered. This affected one resident (#62) of one resident reviewed for non-pressure wound care. The facility census was 59. Findings include:Record review revealed Resident #62 was admitted to the facility on [DATE] with diagnoses including type II diabetes and hidradenitis suppurativa.Review of a minimum data set (MDS) assessment dated [DATE] revealed Resident #62 had moisture associated skin damage (MASD).Review of a care plan dated 10/13/25 revealed Resident #62 was at risk for skin impairment related to weakness, cognitive deficit, incontinence, impaired mobility, thin and fragile skin, falls, and autoimmune disease. The goal was to maintain or develop clean and intact skin by the review date. Interventions included but were not limited to keep skin clean and dry, use lotion on dry skin, do not apply on broken skin; monitor/document location, size, and treatment of skin injury, report abnormalities, failure to heal, signs and symptoms of infection, maceration to provider; weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of issue and exudate and any other notable changes; and follow facility protocols for treatment of injury.Review of orders revealed an order dated 11/18/25 for Resident #62 to receive a skin treatment daily including: cleanse with chlorhexidine wash and pat dry, apply clindamycin gel topically to wound and cover with ABD pad, apply nystatin powder topically to peri-wound. The order was discontinued on 12/19/25.Review of a treatment administration record for 12/2025 revealed the daily wound care treatment for Resident #62 was not completed on 12/11/25, 12/12/25, 12/16/25, and 12/18/25.Review of orders revealed an order dated 12/19/25 for Resident #62 to receive a skin treatment daily including: cleanse with chlorhexidine wash and pat dry, apply clindamycin gel topically to wound, apply calcium alginate and cover with ABD pad, and apply nystatin powder topically to peri-wound.Review of a treatment administration record for 12/2025 revealed the daily wound care treatment for Resident #62 was not completed on 12/21/25, 12/25/25, 12/30/25, and 12/31/25.Review of a treatment administration record for 01/2026 revealed the daily wound care treatment for Resident #62 was not completed on 01/03/26, 01/04/26, and 01/05/26.Interview on 03/03/26 at 3:29 P.M. with Assistant Director of Nursing (ADON) confirmed the treatments for 12/11/25, 12/12/25, 12/16/25, 12/18/25, 12/21/25, 12/25/25, 12/30/25, 12/31/25, 01/03/26, 01/04/26, and 01/05/26 were not completed as ordered. The ADON stated there was no reason the treatments should not have been completed as ordered and there was no additional documentation.This deficiency represents non-compliance investigated under Complaint Number 2722441. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, and policy review, the facility failed to ensure residents, who were at risk for falls, had their fall prevention interventions implemented as per their plan of care. This affected two residents (#6 and #19) of three residents reviewed for falls. Findings include:1.) Review of Resident #6's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included age related osteoporosis, essential hypertension, hypotension, chronic pain, senile degeneration of the brain, cognitive communication deficit, insomnia, difficulty in walking, abnormalities of gait and mobility, lack of coordination, and need for assistance with personal care. Review of Resident #6's Fall Risk assessment dated [DATE] revealed the resident was considered a high risk for falls. Her risk factors included a history of multiple falls, medications and diagnoses that predisposed her to falls, poor memory and recall, frequent bladder incontinence, and gait abnormalities. Review of Resident #6's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had adequate vision and hearing with the use of glasses and hearing aids. She had clear speech but usually was only to make herself understood and understand others. Her cognition was severely impaired. She was not known to display any behaviors but was known to reject care. She had a functional limitation in her range of motion (ROM) of her bilateral lower extremities. A walker and wheelchair were both indicated to be used as mobility devices. She required partial/ moderate assist with bed mobility, transfers, and toilet transfers. The resident was not indicated on the MDS to have had any falls since her last assessment (a significant change MDS dated [DATE]). Review of Resident #6's active care plans revealed the resident had a care plan in place for having actual falls. The goal was for the resident to resume usual activities without further incident through the review date. The interventions included the need to keep her walker within reach when the resident was in her room. On 03/04/26 at 10:03 A.M., an observation of Resident #6 noted her to be lying in bed on her left, with her eyes closed, and facing the window. Her wheelchair was placed at the side of the bed but there was no sign of a walker being within reach as per her fall prevention interventions. On 03/04/26 at 10:06 A.M., an interview with Certified Nursing Assistant (CNA) #113 revealed she had only worked at the facility for about four months now. She felt she was pretty familiar with Resident #6 and her care needs. She was aware the resident was a fall risk and had known her to fall in the past when she was working. She reported they kept a pretty close eye on the resident and the resident was supposed to wear non-skid socks or shoes when up ambulating. She indicated the resident was able to ambulate at times but she primarily used her wheelchair for mobility. She was not aware if the resident had a walker or not. She accompanied this surveyor to the resident's room and verified she did not have a walker kept in reach, as per her fall risk care plan. 2.) Review of Resident #19's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included chronic pain, unspecified anemia, insomnia, age-related macular degeneration, generalized epilepsy, hypertension, lack of coordination, adult onset diabetes mellitus, hemiplegia and hemiparesis following a non-traumatic intracranial hemorrhage affecting her right dominant side, muscle weakness, reduced mobility, need for assistance with personal care, and unspecified fracture of the lower end of right femur, subsequent encounter for closed fracture with routine healing. Review of Resident #19's last quarterly Fall Risk assessment dated [DATE] revealed the resident was considered a high risk for falls. Her risk factors included the use of medications and diagnoses that predisposed her to falls, memory and recall ability concerns, being totally incontinent, confined to a chair, and the inability to independently come to a standing position. She also had an decrease in muscle coordination. Review of Resident #19's annual MDS assessment dated [DATE] revealed she had adequate vision with use of corrective lenses. Her speech was clear and she was usually able to make herself understood and usually able to understand others. Her cognition was intact and she was<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | not known to display any behaviors or reject care. She had a functional limitation in her range of motion on one side of the upper and lower extremities. A wheelchair was used as a mobility device. She required substantial to max assistance with bed mobility and was dependent on staff for transfers. She was not identified as having had any falls since her prior assessment. Review of Resident #19's active care plans revealed she had an active care plan in place for being at risk for falls related to impaired mobility, pain and weakness. The goal was for the resident to have a decreased opportunities for falls through the review date. Her interventions included the need to encourage her to request assistance, if she dropped items on the floor. They were also to provide her with a reacher/ grabber and to encourage her to use it. On 03/04/26 at 10:32 A.M., an observation of Resident #19 noted her to be lying in bed in a supine position. Her upper body was leaning to the upper left side of the bed. She had an air mattress in place and a perimeter overlay over top of the air mattress. She had assist bars up on her bed and her call light was in reach. She was not noted to have a reacher/ grabber within reach as per her fall risk care plan. An interview with the resident at the time of the observation revealed she had a reacher/ grabber around there somewhere but confirmed it was not within her reach. She was not sure where it was at the present time. Observations of her room revealed there was an additional back section of the resident's bed area that had equipment such as wheelchairs stored. A reacher/ grabber was observed lying on top of a nightstand that was not within the resident's reach. The resident reported she would like to have it in her reach in case she needed to reach for something. On 03/04/26 at 10:40 A.M., an interview with LPN #200 revealed she was new to the facility and it was only her second day there. She was still trying to familiarize herself with all the residents and their specific care needs. She confirmed Resident #19 did not have her reacher/ grabber within her reach and verified it was part of her fall prevention interventions. She was informed the resident had requested that it be placed within her reach and went to the resident's room to do so. Further observation of the resident later that day, noted her to have her reacher/ grabber in reach. Review of the facility's policy on Fall Risk Assessments revised December of 2007 revealed the nursing staff, in conjunction with the attending physician, consultant, pharmacist, therapy staff, and others, would seek to identify and document resident risk factors for falls. The staff and attending physician would collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that were not modifiable. Review of the facility's policy on Falls and Managing Fall Risk revised December 2007 revealed, based on previous evaluations and current data, the staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. In conjunction with the attending physician, staff would identify and implement relevant interventions to try to minimize serious consequences of falling. The staff would monitor and document each resident's response to interventions intended to reduce falling or the risk of falling. If interventions had been successful in preventing falling, staff would continue the interventions or reconsider whether those interventions were still needed if a problem that required the intervention had resolved. This deficiency represents non-compliance investigated under Complaint Number 2731858 and 2722441. |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of an Emergency Medical Service (EMS) run report, review of the facility's incident and accident log for the past six months, review of a facility investigation, interview, and policy review, the facility failed to ensure Agency Licensed Practical Nurse (LPN) #100 followed proper medication administration procedures when preparing and administering medications to Resident #42 resulting in a significant medication error. This resulted in Immediate Jeopardy and Actual Harm on [DATE] at 8:23 P.M., when Resident #42 was erroneously given medications that included Xanax 2 milligrams (mg) by mouth (po), Oxycodone 10- 325 mg po, and Gabapentin 800 mg po during an evening medication administration pass that were physician ordered and intended for his roommate (Resident #15). Due to the significant medication error, Resident #42 had a serious change/deterioration in his condition (altered mental status and decreased level of consciousness). After it had been made known to the facility by Resident #15 that his and Resident #42's medications had been inadvertently mixed up and each received the other's ordered medications, the facility failed to timely identify and correlate the reported medication mix up with the change in Resident #42's condition. LPN #100 did not contact the physician to notify him of the reported medication error or to seek medical intervention/ guidance, when the resident was noted to be lethargic on [DATE] at 8:53 P.M. An on-call physician was not contacted and Resident #42 was not transferred to the hospital for an evaluation, until his condition further deteriorated, and he was found unresponsive, hypotensive, and bradycardic on [DATE] at 1:15 A.M. resulting in a delay in treatment. While hospitalized Resident #42 underwent an endotracheal intubation for airway compromise, had a central venous catheter placed for stable intravenous access, and was admitted to the Intensive Care Unit for ongoing monitoring and treatment. Resident #42 remained hospitalized through [DATE], before being readmitted back to the facility. On [DATE] at 4:04 P.M., the facility's Administrator was notified Immediate Jeopardy began on [DATE] at 8:23 P.M., when Resident #42 was given medications ordered and intended for his roommate (Resident #15). As a result of the significant medication error, Resident #42 was found to be lethargic beginning on [DATE] at 8:53 P.M. The resident continued to show signs of an altered mental status and decreased level of consciousness through [DATE] at 1:15 P.M. when he was found to be unresponsive, hypotensive, and bradycardic. It was not until this point the nurse reached out to the on-call physician to obtain an order for Resident #42 to be transferred to the hospital for an evaluation. The nurse did not make it known to the on-call physician, EMS personnel, or the receiving hospital that it was suspected Resident #42 received the wrong medication that evening, contributing to his change in condition delaying prompt and appropriate medical intervention.The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective action: - On [DATE] at approximately 4:15 P.M. the [NAME] President (VP) of Clinical Services created the performance improvement plan (PIP) which was presented to the Director of Nursing (DON). The DON was to start the PIP on [DATE] which would go through [DATE] and assign a designee to assist with the PIP. The DON assigned the Assistant Director of Nursing (ADON) to assist with medication audits. The medication audits were designed to address performance criteria for passing medications such as timing of administration, sanitation, security, resident identification per facility policy and procedure, resident privacy, medication pass, medication preparation, ensuring the medication administration record (MAR) was read prior to preparing medications, documentation, controlled substances, vital signs, interactions, directions for preparing/administering/manufactures specifications, oral medications, oral/intranasal inhalers, eye drops, patches, injectables, tube feeding, crushed meds, multi-dose containers, change of directions, and expired meds. - On [DATE] at approximately 5:00 P.M. the DON began an investigation for a possible medication error requiring Resident #42 to be sent to hospital. - On [DATE] at approximately 5:10 P.M. the DON interviewed LPN #100 and got LPN #100's statement of the incident.- On [DATE]<br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | at approximately 5:20 P.M. the DON interviewed LPN #135 working the night of the event and received LPN #135's statement.- On [DATE] at approximately 5:30 P.M. the DON interviewed Certified Nursing Assistant (CNA) #150 who worked with Resident #42 the night of the event. - On [DATE] at approximately 6:00 P.M. the DON interviewed Resident #42's roommate (Resident #15) to get his statement.- On [DATE] at approximately 7:00 P.M. the investigation of the incident showed an issue on how medication was prepared and administered. The medication was given in the dark and two residents, #42 and #15 medications were prepared at the same time. The corrective action taken was education on proper medication administration and the five rights of medication administration. - On [DATE] at approximately 8:00 P.M. the DON initiated an in-service on Safe Medication Administration Techniques and Change of Condition with nurses currently on shift regarding the possible medication error that occurred when LPN #100 possibly gave the wrong medications on [DATE] to Resident #42 and Resident #15 that resulted in Resident #42 being transferred to the hospital. - Beginning on [DATE], the facility implemented a plan for the DON/Designee to educate nurses on changes of condition and five rights of medication administration followed by medication administration audits. All current full time licensed nurses (9 LPN's and 10 Registered Nurses (RNs) education was completed by [DATE] (in person and via an education book). The facility implemented a plan for any new LPNs and/or RNs to be educated upon hire by unit manager(s). This education included agency nurses as they were scheduled. - On [DATE], the facility determined they would continue the process for an agency nurse resource guide binder to be available for agency staff to review. - Beginning on [DATE] the DON/ADON began auditing changes in condition daily in clinical meeting one time a day for two weeks, then two times a week for eight weeks and then weekly for three months. Audits were scheduled to continue through [DATE]. The results of the audits would be reviewed through the facility Quality Assessment and Performance Improvement (QAPI) process, and any issues would be addressed as needed. - Beginning on [DATE], the DON/ ADON began medication audits and would continue as stated in PIP; one time a day for two weeks, then two times a week for eight weeks and then weekly for three months. The DON would audit proper identification of residents to ensure picture identification was available on residents at this same frequency. These audits included agency nurses as scheduled. Audits were scheduled to continue through [DATE]. The results of the audits would be reviewed through the facility Quality Assessment and Performance Improvement (QAPI) process, and any issues would be addressed as needed.- On [DATE] at approximately 11:00 A.M. interviews were conducted by the DON with two RNs and two LPNs who had worked three days prior to the incident/event. - On [DATE] at approximately 11:00 A.M. skin checks and health assessment (mental status and level of alertness for changes outside of their baseline) were completed on nine of 23 residents with Brief Interview for Mental Status (BIMS) score of eight or less by the ADON to determine whether any resident(s) had a change in condition or medication adverse effects. - On [DATE] at approximately 1:00 P.M. the current policies and procedures for medication administration and change in condition were reviewed by VP of Clinical Services and DON.- On [DATE] at approximately 2:00 P.M. the physician saw and assessed Resident #15 with result of the visit showing no changes in condition related to medication adverse effects upon examination related to possible medication errors. Physician also reviewed medications for Resident #42 at this time.- A review was completed on [DATE] by the DON, on the process that was in place prior to the [DATE] event for agency staff, including resident rights. Report forms were given to all nursing staff at the beginning of shift that inform a nurse on how residents take their medication. After the review was completed areas identified that needed to be added to the process were the five rights of medication administration and change in condition policy/education. - On [DATE] at approximately 10:00 A.M. resident interviews were started by Social Services for residents with a BIMS of 9 or higher and completed at approximately 4:00 P.M. Fourteen of 23 residents were interviewed by the licensed social worker (LSW). The interview questions pertained to life satisfaction survey- abuse and neglect with last question focusing on whether residents feel comfortable reporting any issues or concerns? - (continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On [DATE] at approximately 10:00 A.M. the DON completed a one-on-one in-service with LPN #100, the nurse involved with the incident on [DATE] on safe medication administration and change in resident conditions. - On [DATE] at approximately 11:00 A.M. the DON initiated an in-service with the nursing department which included (9 LPNs and 10 RNs) related to when to notify the DON of any accidents/incidents causing injury or no injury, significant physical, mental, or psychosocial changes, medication errors, any emergency that arises in the building or with residents. This education was completed on [DATE]. Any new LPNs and/or RNS would be educated upon hire by unit manager (s).- On [DATE] at approximately 2:00 P.M. LPN #100, who was responsible for the medication error involving Resident #42, was placed on the Do Not Return list to work at the facility. - On [DATE] at approximately 4:00 P.M., the medical director requested that all residents had a picture in their chart to prevent future medication errors. An immediate audit was completed on [DATE] at approximately 5:00 P.M. by the DON/ Designee. - On [DATE] at approximately 6:30 P.M. Resident #42 returned from the hospital and the physician reviewed medications for the resident at that time. - On [DATE] at approximately 3:00 P.M. Resident #42 was seen by the provider and all medications and documents were reviewed and approved. - On [DATE] at approximately 3:40 P.M. Social Services conducted an interview with residents on South Hall who had a BIMS score of nine or higher (14 of 23 residents) to see if they had any concerns with receiving any other residents' medications. - The facility implemented a plan for the incident that occurred on [DATE] to be discussed at the next QAPI meeting in [DATE] (undetermined date at this time). All audits would be reviewed during the facility QAPI process, and any issues would be addressed as needed.Although the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective actions and monitoring to ensure on-going compliance. Findings include: Review of Resident #42's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including dementia, neurocognitive disorders with Lewy Bodies, unspecified mood disorder, major depressive disorder, anxiety disorder, congestive heart failure, hypertension, cirrhosis of the liver, muscle weakness, lack of coordination, difficulty walking, and insomnia.<br><br>Review of Resident #42's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and was cognitively intact. He was not known to display any behaviors and was not indicated to have received any anti-anxiety medications or opioids.<br><br>Review of Resident #42's active physician's orders, as of [DATE], revealed the resident had orders to receive the following medications: Abilify (an anti-psychotic sometimes used as conjunctive therapy for major depression not receptive to antidepressants) two mg po every (q) morning (am) for depression, Aspirin Enteric Coated 81 mg po q am, Atorvastatin (cholesterol lowering medication) 80 mg po q night at bedtime (hs), Vitamin D 2,000 units po q am, Plavix (an antiplatelet) 75 mg po q am for blood clot prevention, Aricept 5 mg po q hs for dementia, Fluoxetine (an antidepressant) 30 mg po q am for depression, Lactulose 30 milliliters (ml) po three times daily, Magnesium Oxide 400 mg po q am, Melatonin 10 mg po q hs for insomnia, Remeron 7.5 mg po q hs for appetite stimulant, Potassium Chloride 20 milliequivalents (meq) po twice a day for hypokalemia, Sennosides (constipation medication) 8.6 mg (two tablets) po twice a day for constipation, and Tamsulosin HCL 0.4 mg po q hs for an enlarged prostate. The resident's medications ordered on an as needed (prn) basis active as of [DATE] included Acetaminophen for general discomfort, artificial tears prn for dry eyes, Mucinex prn for congestion, and Zofran prn for nausea. He was not ordered to receive a benzodiazepine for anxiety or a narcotic pain medication for pain.<br><br>Review of Resident #42's nurses' progress note revealed a nurse's note by Agency LPN #100 dated<br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | [DATE] at 1:51 A.M. that indicated at approximately 8:00 P.M. the nurse checked on the resident and administered his medications to him. The resident complained of feeling tired from a room change that occurred earlier that day. The nurse helped prepare the resident for bed. The nurse's note further indicated at approximately 8:53 P.M. she went to do rounds on the resident, and his wife was at his bedside. The wife said he (Resident #42) was sleeping and hadn't woken up during the time she had been there. The nurse attempted to wake the resident, and he reacted to touch but was lethargic. The resident was able to grasp her hands and push his feet against her hands when requested showing the ability to follow command. The nurse obtained his vital signs which included blood pressure 108/72mm/Hg (normal 120/80), heart rate was 68 beats per minute (normal 80-100), respiration rate 17 per minute and temperature was 98.1 degrees Fahrenheit (F.). The wife indicated that she would just come back tomorrow and let the resident rest.<br><br>The note included the nurse (LPN #100) documented she went back to check on the resident throughout the night, and he seemed to be sleeping peacefully. He was still reactive to touch but remained lethargic. At approximately 1:15 A.M., the nurse went to check on the resident again and he was more lethargic than previously noted throughout the night. The resident wasn't responding to stimuli. The nurse attempted a sternal rub (movement using the knuckles of your hand in an up and down motion to elicit a response from an unresponsive resident) on the resident with no reaction. The nurse obtained another set of vital signs and noted the resident's blood pressure was 96/62 mmHg (hypotensive, meaning low blood pressure) and the resident had a radial pulse rate of 62 beats/minute. His oxygen saturation was 92% on room air (lower side of normal). The on-call physician was contacted, and an order was received to transport Resident #42 to the emergency department (ED) for an evaluation. Emergency Medical Services (EMS) was contacted about the need for transport and arrived at the facility at approximately 1:45 A.M. The nurse gave report to EMS personnel upon their arrival.<br><br>Review of Resident #42's Skilled Nursing Facility/ Nursing Facility to Hospital Transfer Form dated [DATE] at 1:45 A.M. completed by LPN #100 revealed Resident #42's reason for transfer was an altered mental status. Resident #42 was also noted to have a blood pressure reading of 96/62 mmHg (hypotensive). Relevant diagnoses included dementia and difficulty in walking.<br><br>Review of Resident #42's EMS Run Report dated [DATE] revealed EMS responded to the facility after a call was received at 1:26 A.M. for an unconscious or fainting individual. They were on-site at 1:37 A.M. The chief complaint was bradycardia (slow heart rate), and a secondary complaint was hypotension (low blood pressure). The resident was noted to have a significant medical history for congestive heart failure, dementia, hypertension, cirrhosis of the liver, anxiety, tremors, myocardial infarction (MI), and encephalopathy. His current medications included Cholecalciferol (Vitamin D), Fluoxetine, Acetaminophen, Plavix, Tamsulosin, Lactulose, Donepezil, and Melatonin. He was assessed to be in moderate distress and there were no reported factors of drug use affecting care. The resident was unresponsive with a primary impression of unconsciousness. He responded to painful stimuli. His Glascow coma scale was seven (a total score of 8 or less is generally indicative of a severe brain injury or coma) with eye opening to painful stimuli, withdrawal from pain, and no verbal response. His vital signs revealed hypotension with a blood pressure of 80/52 mmHg. His blood sugar was 133 milligrams/ deciliter (mg/ dl). The resident was administered Narcan (a medication used to rapidly reverse an opioid overdose) four mg intranasally, due to the resident being assessed to have pinpoint pupils. Intravenous (IV) therapy was initiated into the resident's left forearm for IV administration of 0.9 Normal Saline. The resident was administered an additional 2 mg of Narcan IV and subsequently 1 mg of Atropine IV. Upon arrival at the hospital, the resident's condition was noted to have improved, but he was still unresponsive.<br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of the facility's incident/accident log for the past six months revealed an incident dated [DATE] for Resident #42 included under other incidents.<br><br>An interview with the DON on [DATE] at 2:54 P.M. clarified the other incident that was documented as having occurred with the resident on [DATE] at 1:15 A.M. pertained to the resident's transfer out to the hospital for unresponsiveness. The resident reportedly had a room change that occurred earlier that day and became tired/weak from that. She was asked if the resident's symptoms were possibly related to receiving the wrong medication(s) and she indicated that it was possibly medication related. She indicated the facility conducted an investigation into the incident, but she did not feel she was able to determine that was the cause. She was asked to provide the investigation for review.<br><br>Review of the facility's investigation of the incident involving Resident #42's change in condition occurring on [DATE] at 1:15A.M. revealed it included incident statements the DON received from several employees, including an agency nurse (LPN #100), who all worked on the evening of [DATE] into the morning hours of [DATE]. The investigation file also included an investigation worksheet, hospital records pertaining to Resident #42, medication administration records (MARs) for Resident #15 and #42, and a performance improvement plan (PIP).<br><br>Review of an incident statement from Agency LPN #100 obtained by the facility's DON dated [DATE] at 5:10 P.M. revealed the nurse indicated to the DON that she went into Resident #42's room to give him his evening/ bedtime medications, when the resident reported he was tired. After giving him his medications, she helped the resident put his feet up in bed and he laid down. The nurse did not bother him again until his wife informed her the resident did not wake up during her visit. The wife put her cold hands on the resident, but he still did not wake up. That was when the nurse reported she had become a little concerned. The resident was still alert at the time and could open his eyes. He was also able to squeeze her hands and everything. She just figured he was tired, so she left him alone but kept going back and checking on him. When he did not respond to verbal commands to squeeze her hand, or her shaking him, or to a sternal rub that was when she called the physician. The wife reportedly arrived at the facility around 8:53 P.M. The nurse did not know the wife was there until she went back to the room to inform the roommate (Resident #15) that he had already been given his pain medication. Resident #15 had complained to an aide earlier that he was still having pain and said his pain medications did not work. The aide had previously told him he had already got his medications, but the nurse was going to tell him the same. That was when the nurse said she saw Resident #42's wife and was told about the resident not waking up during her visit. The nurse assessed the resident, but the resident acted like he was just sleepy. She got another nurse (LPN #135) to check him, and they both just thought the resident was sleepy from moving earlier that day. She did not think anything about it until he stopped responding later in the evening. She was asked by the DON if she remembered when she originally went into the resident's room and indicated it was at the beginning of her shift, sometime around 8:00 P.M., when she gave him his medications and the resident told her he was tired. She denied she noticed anything else about the resident at that time. The DON then asked the nurse if the resident got worse and became more lethargic as the night went on. The nurse responded that was correct. Once he was like that, she called the provider because the resident was a full code. The wife saw that the resident was not awake after they tried to get him to drink his milkshake. The nurse reported the wife was like oh well, she would just come back tomorrow telling the staff to just let him rest. The nurse then left the resident's room and just returned routinely to check on him. He was still able to respond, at least a little bit, during her follow-up checks. Once he stopped responding, she called the provider. His vital signs remained around 108 (not clear what vital sign she was referencing). Since the nurse did not really know the resident, she asked the wife when she was there if the resident normally slept that deep. The wife responded sometimes, not really, but<br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | the nurse did not feel the wife seemed concerned and that he was just in a deep sleep. The nurse was asked by the DON how she prepared her medications for that room. The nurse admitted she prepared them at the same time pulling them both out and popping them both into medication cups that she wrote their names on. She crushed Resident #42's pills and mixed them with pudding before taking them to him. She then went back and gave his roommate (Resident #15) his pills whole. The DON asked the nurse if the roommate said anything about getting the wrong medications. The nurse admitted the room was dark when she gave Resident #15 his medications, but he took them. Twenty (20) minutes later he was complaining to his aide (CNA #150) that he didn't feel like he got his medications because he could normally tell 10 minutes after he took them and that time, he did not feel that way.<br><br>Review of an incident statement from LPN #135 obtained by the facility's DON dated [DATE] at 5:19 P.M. revealed she was asked by Agency LPN #100 to come back to Resident #42's room to check on him. When she got back to the room, the resident's wife was there. The nurse reported she did not work with Resident #42 that much, but something just seemed off. His vital signs were stable, but he had just moved and they all thought maybe it was just the move or something like that. The aide (CNA #150) continued to do his rounds and the other nurse (Agency LPN #100) went back and checked on him every once in a while. The staff came and got her a second time to check on the resident. That time she said she was like somethings just not right. His vitals were low, but they were still you know he was, she just had a bad feeling so she looked up his code status, and he was a full code. She told the other nurse, Agency LPN #100 he was a full code, and he needed to go out because the resident was not even like he was the first time. She was only able to get the resident to kind of squeeze her hand, after a little time and he fluttered his eyes and moved his feet well the first time, but when they went in prior to calling the squad he would not do any of that. She told the other nurse there was something wrong with him and he needed to go out. She was asked if there was anything else she remembered. She told the DON the roommate was saying well she gave him (Resident #42) his (Resident #15's) pills. The other nurse responded and told her she swore that she did not. She replied she was not there, so she did not know but they did give him (Resident #42) Narcan. His pupils were pinpoint, but he had no response to the Narcan. The EMS only administered one dose of the Narcan while there. She was not sure if they gave him anymore after they left. The EMS did say it could take up to 15 minutes for a response. Even after he was loaded in the truck, the resident was still not responding. She then denied she heard anything directly from the roommate about his medications. What she heard about Resident #42 getting Resident #15's medications came from the nurse (Agency LPN #100).<br><br>Review of an incident statement from CNA #150 obtained by the facility's DON dated [DATE] at 5:30 P.M. revealed Resident #42 was acting himself at first mumbling. He did not seem out of his normal and he was usually tired. It was usually hard to understand the resident but later he became more lethargic. His family brought him McDonalds, and the resident seemed like he was coming out of it, or so they thought. His vitals were fine. Around midnight, he started getting worse. The resident was not interacting with him as much. He denied he got anything in report about Resident #42, or that there was a resident that they really needed to watch. He was asked by the DON if there seemed to be anything abnormal for the resident when he first arrived on shift. He stated he could not tell anything different at first, but the resident took a drastic turn after his wife left and he thought that was sometime between or around midnight.<br><br>Review of Resident #42's MAR's for [DATE] that was included in the facility's investigation file revealed Resident #42 should have been given the following medications ordered at bedtime (hs) on [DATE]: Atorvastatin 80 mg po, Donepezil HCL 5 mg po, Melatonin 10 mg po, Remeron 7.5 mg po, (continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Tamsulosin HCL 0.4 mg po, Potassium Chloride 20 meq po, Senna 8.6 mg two tablets po, and Lactulose 30 ml po. The nurse administering those medications was identified as being Agency LPN #100. The medications given to the resident were his 6:00 P.M. medications, also noted to be his hs medications. A medication administration audit report showed he was documented as having received those medications on [DATE] at 8:44 P.M.<br><br>Review of Resident #42's roommate's (Resident #15's) MAR for [DATE] revealed Resident #15 was scheduled to receive the following medications at bedtime on [DATE]: Atorvastatin 40 mg po, Xanax 2 mg po, Eliquis 5 mg po, Sinemet 10-100 mg po, Gabepentin 800 mg po, and Percocet 10-325 mg po. The medications were signed off as having been given by Agency LPN #100. A medication administration audit report revealed he was documented as having received those medications on [DATE] at 8:23 P.M. The controlled drug record for the Oxycodone- Acetaminophen (Percocet) 10-325 mg tablet and the Xanax 2 mg tablet were signed out of the controlled medication box on [DATE] at 8:00 P.M. (23 minutes prior to the controlled medication being documented as having been administered).<br><br>Review of Resident #42's hospital records that were included in the facility's investigation file revealed they included Emergency Department (ED) notes, a hospital History and Physical (H&P), and a Discharge Summary from a local hospital. There were additional records from another hospital that Resident #42 had been transferred to.<br><br>Review of Resident #42's ED Triage Note dated [DATE] at 2:31 A.M. revealed the resident arrived at the hospital from the nursing facility, after being found unresponsive. Per the EMS, the resident was responding to pain on arrival and had pinpoint pupils. His blood pressure was 80/50 (low) and heart rate was 45 beats per minute (bpm). He was administered at total of 6 mg of Narcan (medication given to reverse the effects of a drug overdose) and 1 mg of Atropine (medication used to treat a slow heart rate).<br><br>Review of an ED Provider Note dated [DATE] at 4:51 A.M. revealed Resident #42's chief complaint was hypotension, bradycardia, and unresponsiveness. His reported last known well was around 8:00 P.M. (approximately six hours prior to his arrival to the ED). The resident was poorly responsive, but did have a gag reflex, and had some arousability to a sternal rub. He was spontaneously breathing with reasonable rate. EMS reported initial miotic pupils. Narcan was tried with some pupillary response and possibly some initial response in terms of arousability but not maintained and not responsive to additional doses. He was supported with low dose pressor therapy for borderline low pressures. A central line was placed for ICU stability. His social history indicated he was never known to use drugs. Pupils were equal at 3 millimeters, after multiple doses of Narcan (per EMS was reported to be miotic previously). Clinical impression was acute encephalopathy, unresponsiveness, abnormal cat scan (CT) of lung, sinus bradycardia. Other known diagnoses in his history included congestive heart failure (CHF), dementia with Lewy Bodies, and cirrhosis of the liver. He was released from the ED and admitted to the hospital ICU. A Urine Drug Screen collected on [DATE] at 5:03 A.M. revealed the resident tested positive for benzodiazepines (classification of a type of antianxiety medication to include Xanax) and Oxycodone (neither of which the resident had an order to receive but was consistent with what was ordered for his roommate at hs). Review of Resident #42's hospital history and physical (H&P) dated [DATE] at 5:52 A.M. revealed the resident presented from the nursing home with complaints of an altered mental status and unresponsiveness. He was admitted to the hospital ICU with risk variables including conventional mechanical ventilation, acute respiratory failure, pneumonia, and dementia. His hospital diagnoses included acute hypoxic (low<br>(continued on next page) |

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|---|---|---|---|
| | 366250 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kimes Nursing & Rehab Ctr | 75 Kimes Lane<br>Athens, OH 45701 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | oxygen levels in the blood) respiratory failure and multifocal pneumonia. He was mildly hypoxic requiring supplemental oxygen upon arrival, initially maintaining airway; however, he had progressive respiratory decline necessitating endotracheal intubation (plastic tube inserted through the mouth and down the throat for airway access) to maintain airway patency. He was also dia |

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| F 0844<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Follow rules about disclosure of ownership requirements and tell the state agency about changes in ownership and/or administrative personnel.<br><br>Based on record review and interview, the facility failed to update the state agency regarding a change in administration. This affected all 59 residents residing in the facility. The facility census was 59. Findings include:Review of the enhanced information dissemination and collection (EIDC) website revealed the current Administrator and the interim Administrator from November (2025) through January (2026) were not listed. Interview on 03/04/26 at 1:01 P.M. with the Administrator confirmed the facility had failed to notify the state survey agency with changes in administrators including the current Administrator. This deficiency represents an incidental finding of non-compliance investigated under Complaint Number 2735791 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview, and policy review, the facility failed to ensure a staff nurse donned appropriate personal protective equipment (PPE) before entering the room of a resident in transmission based precautions for Covid-19. This affected one resident (#30) of two residents reviewed for medication administration pass. Findings include:On 02/26/26 at 8:26 A.M., an observation during a medication administration pass for Resident #30 on the North hall noted Registered Nurse (RN) #154 to enter the room of the resident to give the resident her morning medications. While the nurse was in the room, Resident #30 had reported to the nurse that it was her last day of being in isolation for being positive for Covid-19. She further went on to tell the nurse that it was her tenth day of being in isolation and was looking forward to it ending. RN #154 entered the room only wearing a N-95 particulate mask all staff were wearing throughout the facility and a pair of gloves. She did not don a gown before entering the room. After the medication pass was complete and Resident #30's room was exited, observations of the hall area outside the resident's room revealed she did have a PPE cart outside the door. There was also a sign noted resting on the handrail outside the resident's room to the right of the door that was positioned diagonally against the wall and not in an area that was prominent or easily identifiable. There was some equipment being stored in the hall in that general area that further made it hard to see the sign where it was positioned. The sign did identify the resident as being on Droplet Precautions. Review of Resident #30's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included congestive heart failure, chronic kidney disease, hypertensive heart disease, and morbid obesity. Review of Resident #30's nurse's progress notes revealed a nurse's note by RN #108 dated 02/16/26 at 12:45 P.M. indicating the resident was tested for Covid-19 on that date for the following symptoms: headache, chills without fever, and a sore throat. The nurse's note indicated that positive test results for Covid-19 were noted. Review of Resident #30's active physician's orders revealed there was not an order in place that specified the need for her to be in TBP's for Covid-19, or the length of time in which she would be in isolation. It only included an open ended order that Covid-19 testing could be completed as needed. On 02/26/26 at 9:45 A.M., an interview with RN #154 confirmed she did not don a gown before entering the room of Resident #30 to giver her her morning medications. She stated she was aware the resident was in isolation precautions for being positive for Covid-19. She did not don a gown because there were not any gowns available in the PPE cart outside the room. She stated she could have checked one of the other PPE carts but did not before going into the room. She acknowledged a gown was part of the PPE that should be worn when going into a room of a resident who was positive for Covid-19. She further acknowledged the sign that identified the resident as being in Droplet Precautions was not prominently displayed and wasn't posted on the door where it would be easily visible when the door was shut. Review of the facility's policy on Covid-19 revised 05/11/23 revealed healthcare providers (HCP) who enter the room of a patient with suspected or confirmed Covid-19 infection should adhere to standard precautions and use a NIOSH approved particulate respirator with N-95 filters or higher, gown, gloves, and eye protection (i.e. goggles or a face shield that covered the front and sides of the face). In general, patients who were hospitalized with Covid-19 infections should be maintained in TBP's for the time period described for patients with severe to critical illness. Patients who were asymptomatic (no symptoms) throughout there infection and were not moderately or severely immunocompromised, or who had mild to moderate illness who are not moderately or severely immunocompromised should be in TBP's at least 10 days, since the date of their first positive viral test. This deficiency represents an incidental finding of non-compliance investigated under Complaint Number 2735791. |

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| F 0940<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Develop, implement, and/or maintain an effective training program for all new and existing staff members.<br><br>Based on record review and interview, the facility failed to maintain and effective training program for staff. This affected all 59 residents residing in the facility. The facility census was 59. Findings include:1.Review of personnel files revealed Certified Nursing Assistant (CNA) #183 was hired on 12/19/25.Further review of the file revealed CNA #183 did not having training for compliance and ethics, quality assurance program, effective communication, and behavioral health.2.Review of a personnel file revealed CNA #150 was hired on 10/08/25.Further review of the file revealed CNA #150 did not have training for compliance and ethics, quality assurance program, and behavioral health.Interview on 03/04/26 at 3:04 P.M. with Human Resources (HR) #158 confirmed required training was not completed for CNAs #183, #150.This deficiency represents an incidental finding of non-compliance investigated under Complaint Number 2735791. |