STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366261	A. Building B. Wing	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Enclave at Barnesville	400 Carrie Avenue Barnesville, OH 43713

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, review of facility policies, and interview, the facility failed to develop and implement comprehensive, individualized and adequate pressure ulcer interventions to prevent the development of a pressure injury/ulcer for Resident #55. This affected one resident (#55) of one resident reviewed for facility acquired pressure injuries. The facility census was 52. Actual harm occurred on 03/26/26 when Resident #55, who was assessed to be dependent on staff for personal care including turning and repositioning in bed, had multiple hospitalizations placing her at high risk for development of pressure injuries, was not provided necessary and appropriate interventions to prevent the development of a pressure injury and subsequently developed an unstageable pressure injury (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) to her right buttock gluteal fold resulting in the resident experiencing increased pain during movement and pressure injury treatments. Findings Include: Review of the medical record for Resident #55 revealed admission to the facility on [DATE] with diagnoses of chronic respiratory failure, oxygen dependence, lung disease, fibromyalgia, diabetes, depression, anxiety, high blood pressure, chronic kidney disease stage 4, gastric reflux, cirrhosis of the liver. New diagnosis of a pressure ulcer injury of right buttock was added on 03/21/26 and a diagnosis of fall with brain bleed was added on 04/23/26.On 01/10/26 there was a physician order to start (on 01/11/26) the application of house barrier cream to peri-area/buttocks after each incontinence episode and as needed to prevent skin breakdown, may leave at bedside.Review of Resident #55's care plan titled Actual Skin Breakdown related to Unstageable Gluteal Fold initiated on 01/11/26 and revised on 04/13/26 revealed the following interventions: apply barrier cream after each incontinent episode and as needed, assist the resident to reposition and/or turn at frequent intervals to provide pressure relief, keep skin clean and dry, report changes to skin integrity to nurse, teach resident/family the importance of changing positions for prevention of skin breakdown and encourage small frequent position changes.Review of Resident #55's task documentation January 2026 through May 2026 (where direct care staff documented care being provided to the resident) revealed no evidence staff assisted the resident with turning and repositioning to provide pressure relief or evidence of offloading pressure, and evidence of encouragement/education of the resident for frequent position changes. Review of the Minimum Data Set (MDS) 3.0 initial comprehensive assessment completed with modifications dated 02/05/26 revealed Resident #55 had no hearing or visual impairments and the resident was able to make her needs known and understand others. Further review revealed a Brief Interview for Mental Status score of 15/15 indicating Resident #55 was cognitively intact. Review of section GG of the MDS revealed Resident #55 was dependent on staff for transfers, dressing, bathing, hygiene, bed mobility, and personal care. Resident #55 was utilizing a mechanical lift by staff for transfers and was not mobile at time of assessment. Review of section M of the MDS assessment for Resident #55 revealed she was at risk for the development of pressure injuries and on admission to the facility there were no current skin issues. Further review of section M of the MDS 3.0 revealed use of pressure relieving device to chair and bed as well as use of ointment/creams for prevention of pressure ulcers for (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #55. Review of the Braden Scale Assessment (nationally recognized tool to evaluate pressure injury risk) completed on 02/10/26 revealed a score of 15/22 indicating Resident #55 was at moderate risk for pressure ulcer development. Per the Braden Scale Assessment, the resident required staff assistance with positioning.Review of Resident #55's physician/medical provider orders revealed no evidence of orders for pressure relieving devices for the chair or bed. Review of the Nurse Practitioner (NP) history and physical skin and wound assessment completed by NP #302 on 03/05/26 revealed Resident #55's skin was intact (no wounds noted) and the resident remained at high risk for skin breakdown due to mobility limitations and comorbid conditions (chronic medical issues).Review of the weekly skin assessment for Resident #55 dated 03/13/26 revealed no evidence of an unstageable pressure injury to the right buttock gluteal fold. A nursing progress note dated 03/19/26 revealed Resident #55 went out to the hospital on [DATE] due to critical sodium levels.The resident was admitted to the hospital for treatment and returned to the facility on [DATE]. Review of the re-entry nursing assessment for Resident #55 completed on 03/21/26 by Registered Nurse (RN) #223 revealed the presence of moisture associated skin damage (MASD) to the resident's bilateral buttocks. There was no evidence of measurements or presence of any wounds or pressure injury documented. There was no evidence of interventions in place or treatments of MASD or any interventions for pressure relief. There was no evidence the facility implemented pressure injury interventions including pressure reduction in the resident's wheelchair, offloading pressure to the resident's buttocks, and implementing frequent turning and repositioning even though the resident was at an increased risk for pressure injury development based on the recent hospitalization and the skin impairment identified as MASD by the facility.Review of the nurse progress notes revealed on 03/24/26 Resident #55 left the facility in her wheelchair to attend a physician appointment from 10:40 A.M. with a return at 1:01 P.M. Resident #55 had no pressure injury reduction measures in place in the wheelchair.Review of the Nurse Practitioner (NP) history and physical completed by NP #300 on 03/26/26 revealed the presence of an unstageable pressure injury to the right buttock gluteal fold measuring 5.0 centimeters (cm) in length (l) by 3.0 cm wide (w) by 0.3 cm depth (d) and the wound bed was covered with 100% slough (a film of dead cells and white blood cells). The NP note further recommended wound care to consist of cleansing wound with normal saline, applying medical grade honey to base of wound, and securing with a bordered foam dressing daily and as needed if soiled. However, review of the treatment administration record (TAR) for March 2026 revealed no wound care or treatment performed to the right buttocks for Resident #55 from 03/21/26 (when staff first identified the resident had MASD) until 03/29/26. Review of the nursing progress notes for Resident #55 revealed no evidence or documentation of an unstageable pressure ulcer or treatment from 03/21/26 through 03/29/26. Review of the weekly skin assessment for Resident #55 dated 03/27/26 revealed no evidence of an unstageable pressure injury to the right buttock gluteal fold (even though NP #300 had identified the ulcer on 03/26/26). A nursing progress note dated 03/29/26 at 1:32 P.M. authored by RN #208 revealed when assisting resident to the bathroom, resident stated her bottom is sore, when this nurse assessed resident's bottom, noticed an open area on right gluteal fold measuring 4.0 cm by 2.5 cm by >0.1cm, notified doctor and resident's son. The note included the resident dominates right side when lying in bed.Review of Resident #55's subsequent physician orders revealed an order obtained on 03/29/26 to assess area under right gluteal fold for signs and symptoms of infection, notify physician (MD) every shift until healed. In addition, there was an order to start on 03/30/26 to cleanse area under right gluteal fold with normal saline or wound cleanser, pat dry, apply xeroform gauze (a medicated bandage) cut to wound size and then foam dressing every day shift for wound healing until healed.Continued review of the weekly skin assessments and treatments for Resident #55's pressure ulcer wound to right gluteal fold revealed on 04/02/26 NP #300 staged the pressure ulcer as unstageable and measured at 3.5 cm (l) x 2.5 cm (w) x 0.3 cm (d) with 100 % slough present. An order was recommended to change wound care to cleanse with wound cleanser/normal saline, apply medical grade honey to base of the wound, and apply boarder foam and (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	change daily and as needed if soiled/loose.On 04/09/26 NP #300 noted Resident #55's wound measurements were 3.5 cm (l) x 2.5 cm (w) x 0.3 cm (d) and 10% granulation and 90% slough and continue current wound care. Wound remained unstageable due to presence of slough.On 04/11/26 Resident #55 had a hospitalization for pneumonia, UTI, and subdural hematoma.On 04/23/26 Resident #55 returned to the facility from her hospital admission and a skin assessment was completed by the staff nurse. The assessment identified that the resident had no new skin impairment.On 04/28/26 Resident #55 was hospitalized again for a gastrointestinal bleed but returned to facility on 04/29/26. A skin assessment was completed by a facility staff nurse and noted no new open areas.On 04/30/26 Resident #55 was assessed by NP #300 and noted the right gluteal fold pressure ulcer was now stageable and assessed to be a Stage III pressure ulcer (full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present) with measurements of 3.0 cm (l) x 1.5 cm (w) x 0.3 cm (d) and a wound bed that was 100% granulation. New wound care recommendations were made to start on 05/01/26 to include, cleanse area with normal saline/wound cleanser, apply collagen to wound bed and cover with bordered foam every day shift until healed.Observation and interview on 05/04/26 at 12:30 P.M. revealed Resident #55 sitting in bed eating lunch. At the time of the observation, Resident #55 reported she did have a sore on her buttocks but was unsure how long it had been there or how it was healing. Observation on 05/05/26 at 12:20 P.M. revealed Resident #55 sitting up in wheelchair eating lunch. There was no pressure relieving device noted in the wheelchair. Resident #55 was sitting on a pillow. Observation on 05/06/26 at 1:20 P.M. revealed Resident #55 lying in supine position in bed. There was no evidence of a pressure relieving device for the wheelchair present by the bed. At the time of the observation, interview with Certified Nursing Assistant (CNA) #263 verified there was no pressure relieving device to the resident's wheelchair. Interview on 05/06/26 at 3:10 P.M. with RN #208 revealed that when a resident was at risk for developing pressure injuries the admission nurse would be responsible for getting orders from the doctor or provider for pressure relieving device use. RN #208 verbalized on admission when a resident has a wound, staff notify the Assistant Director of Nursing (ADON) if she was available that day or the next morning during morning report so she could evaluate the resident further. RN #208 revealed pressure injury prevention would include the use of a barrier cream, turning residents every 2-3 hours, and use of special mattress and cushions. RN #208 reported she could not find an order for pressure relieving devices for Resident #55 and that yesterday, 05/05/26, when Resident #55 got up in wheelchair the resident asked for a pillow to sit on for comfort and a pillow was placed. RN #208 further reported that sometimes Resident #55 was not always compliant with turning on her sides to relieve pressure from her buttocks but was encouraged by staff to do so. (Note- there was no documentation the resident was non-compliant with turning and repositioning or offloading pressure.)On 05/06/26 at 3:34 P.M. Resident #55 was observed receiving wound care completed to the right buttock gluteal fold by RN #208. Further observation revealed a pressure injury to the right buttock gluteal fold with a moist pink wound bed that appeared to be free of infection and healing with a scant amount of brownish drainage to the old dressing. During the treatment, Resident #55 was observed to wince, making a vocal noise and pulling her right buttocks away (guarding behavior indicating pain) when RN #208 performed wound care. Resident #55 did verbalize some discomfort with wound care but reported the pain was becoming less from when she initially developed it (the pressure injury). Resident #55 reported she tried to lay on her sides but stated she didn't like lying on her left side and lays on her back or right side mostly. Interview on 05/07/26 at 12:25 P.M. with Nurse Practitioner (NP) #300 revealed she had recently started treating residents at the facility about two months prior. NP #300 reported she completed skin assessments on all newly admitted residents and the re-entry of residents who had been hospitalized (NP #300 had initially seen Resident #55 on 03/26/26 due to the resident's recent re-entry to the facility from the hospital). NP #300 reported RN #215 always rounded with her and they would verbally discuss wound care and treatments. NP #300 reported she would write wound care recommendations on her notes (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	and tell RN #215 verbally the wound care orders, but RN #215 was responsible for entering the wound care orders into the electronic medical record. NP #300 reported there was one week in March (2026) when RN #215 was not available to round with her and was not working. NP #300 reported that on that day she just wrote up her notes with wound recommendations (03/26/26), a report would have been available for RN #215 to review to enter or change any orders. During the interview, NP #300 verbalized she saw Resident #55 for the first time on 03/26/26 as an initial skin assessment since re-entry to the facility after a hospitalization and was not consulted for any specific reason at that time. NP #300 confirmed she diagnosed Resident #55 with an unstageable pressure injury to her right buttock gluteal fold on 03/26/26 and recommended wound care. NP #300 reported she was not aware that the orders for Resident #55 were not entered into the computer or completed from 03/26/26 to 03/29/26. NP #300 reported that the pressure injury to Resident #55 could have been preventable with recommendations of turning and positioning (no evidence this was completed by the facility), use of pressure relieving devices (no pressure relieving device in the resident's wheelchair), barrier creams, and appropriate nutrition. Interview on 05/07/26 at 12:47 P.M. with the MDS Coordinator/Assistant Director of Nursing, RN #215 revealed the most recent MDS assessment from re-entry on 03/21/26 revealed Resident #55 had one unstageable pressure injury present on re-entry from facility was inaccurate. RN #215 confirmed the medical records for Resident #55 revealed the presence of moisture associated skin damage (MASD) to bilateral buttocks on 03/21/26 with no indication of pressure injuries. RN #215 proceeded to update the MDS assessment with modification to reflect no pressure injury present on 03/21/26. Further interview with RN #215 revealed she was the RN responsible in the facility for assessment of wounds weekly and that RN #208 also rounded weekly with the wound nurse practitioner. RN #215 verbalized that the staff nurses would describe the presence of a wound, describe the appearance of the wound, and measure the wound on admission but the staff nurses do not diagnosis or stage pressure injuries/wounds. RN #215 further reported she would assess the wounds the same day or next day she worked to determine if a pressure injury and the stage of the injury. RN #215 confirmed there was no documentation or evidence in the medical record for Resident #55 from 03/21/26 until 03/26/26 indicating the resident had an unstageable pressure injury. RN #215 also confirmed there was no documentation of a wound assessment completed for Resident #55 by RN #215 between 03/21/26 and 03/26/26. Further interview with RN #215 revealed she was responsible for completing and updating the resident care plans. RN #215 verified Resident #55's plan of care initiated on 01/11/26 titled Actual Skin Breakdown related to Unstageable Gluteal Fold was not accurate as Resident #55 did not have actual skin breakdown on 01/11/26 and the resident had not developed the unstageable pressure injury to her right gluteal fold until 03/26/26. RN #215 revealed there were no pressure injury prevention care plans in place for Resident #55 until the development of the unstageable pressure injury to the right buttocks gluteal fold on 03/26/26. Review of the facility policy titled, Pressure Ulcer/Injury Risk Assessment, and revised July 2017 revealed once assessments were conducted and risk factors identified, a resident-centered care plan would be developed to address the modifiable risk for pressure injuries. Further review revealed the risk assessment should be conducted as soon as possible after admission or within eight hours after admission was completed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility records, observation of kitchen and meal service, and interview with staff, the facility failed to store food in a sanitary manner and the drainpipes were maintained to prevent sewage odor in the kitchen. This had potential to affect 52 residents who receive meals from the kitchen. The facility census was 52.Findings Include: 1.Observations on 05/04/26 between 8:10 A.M. and 8:34 A.M. during the initial kitchen tour revealed the dry storage pantry had a strong sewage smell coming from an open drainpipe in the floor. Dietary Manager (DM) #209 verified the odor and reported it had been that way for several months and both administration and maintenance were aware of the concern. Observation and interview on 05/05/26 at 4:20 P.M. with DM #209 revealed the odor in the dry storage area was no longer present. DM #209 reported the Maintenance Director from one of the other facilities came earlier that day and snaked the drain and poured vinegar and baking soda down the drain as well. DM #209 further shared that the drain needed water ran through it monthly to prevent odors and DM #209 was unaware this needed to be completed.2. Observation during the kitchen tour on 05/04/26 between 8:10 A.M. and 8:34 A.M. revealed the walk-in cooler temperature was 42 degrees Fahrenheit, and the walk-in cooler had only one fan working to circulate air. This was verified by DM #209 at that time of the observation. The DM reported administration and maintenance were aware of the broken fan but had not yet fixed it and it had been two weeks, or longer since the fan broke. On 05/05/26 observation of the dinner meal service revealed dietary cook (DC) #231 checked food temperatures prior to serving the dinner meal. The canned beets that were placed in the walk-in cooler at approximately 1:50 P.M. and removed at 4:55 P.M. had a temp of 53.2 degrees Fahrenheit. This was verified by DC #231. The canned fruit cocktail was placed in bowls in the walk-in cooler at approximately 2:00 P.M. and removed at 4:55 P.M. and had a holding temp of 49.0 degrees Fahrenheit. This was verified by DC #231 at the time of the observation.Interview on 05/05/26 at 5:15 P.M. with the facility Chief Executive Officer (CEO) revealed he was aware of the issue with the walk-in cooler fan not working and believed that a part had been ordered from [NAME] or [NAME] may have come and looked at the unit. The CEO reported he would look for invoices or receipts from [NAME].Review on 05/06/26 at 8:00 A.M. of an online order receipt revealed a new fan for the walk-in cooler was ordered on 05/05/26. There was no evidence of the fan being ordered or an estimate provided for repair prior to 05/05/26.Review of the facility Food Receiving and Storage, policy revised 2017 revealed refrigerated foods will be stored below 41 degrees Fahrenheit and will be stored in such a way that promotes adequate air circulation. Further review of the policy revealed foods in designated dry storage areas will be clear of sewage/waste disposal pipes and vents.Review of the United States Department of Agriculture (USDA) website for recommendations for safe handling, Danger Zone (40 F - 140 F) | Food Safety and Inspection Service, revealed cold foods should be kept at or below 40 degrees Fahrenheit, and place food on ice. Further review revealed the danger zone of foods left at temperatures between 40-140 degrees Fahrenheit for as little as 20 minutes can lead to doubling of bacterial growth leading to food borne illness.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview the facility failed to ensure resident assessment data accurately reflected the residents' status. This affected four residents (Resident #8, #29, #30 and #55) of 46 resident records reviewed for accuracy of assessments. The census was 52. Findings include: 1.Review of the medical record for Resident #8 revealed an admission to the facility on [DATE] with diagnoses including urinary tract infection, Parkinson's disease, spinal stenosis, major depression, and high blood pressure. Review of the most recent minimum data set (MDS) 3.0 comprehensive initial assessment completed on 03/30/26 for Resident #8 revealed item N0350 answered 01 indicating that Resident #8 received insulin injections. Review of the physician order for Resident #8 revealed no insulin orders. Review of the medication administration records for March and April of 2026 for Resident #8 revealed no insulin injections provided. Interview on 05/06/26 at 10:41 A.M. with the MDS coordinator, Registered Nurse (RN) #215 revealed that on 05/04/26 after reviewing the Matrix document provided to the survey team at 9:04 A.M. she realized that Resident #8's MDS item N0350 was incorrectly answered as 01 indicating that Resident #8 was receiving insulin injections however after review it was found that Resident #8 did not receive insulin injections and the MDS was modified on 05/04/26 at 2:44 P.M. to reflect the correct answer for N0350 as 00 (no insulin injections received). 2.Review of the medical record for Resident #29 revealed an admission to facility on 04/09/26 with diagnoses including acute respiratory failure, depression, hyponatremia (low salt level in blood), gastrointestinal bleed, anemia, high blood pressure, and hepatic encephalopathy (water on brain leading to confusion). Review of the most recent minimum data set (MDS) 3.0 comprehensive initial assessment completed on 04/23/26 for Resident #29 revealed item N0350 answered 01 indicating that Resident #29 received insulin injections. Review of the physician orders for Resident #29 revealed no insulin orders. Review of the medication administration record for April of 2026 for Resident #29 revealed no insulin injections provided Interview on 05/06/26 at 10:41 A.M. with RN #215 revealed Resident #29 did not have a diagnosis of diabetes and was not ordered insulin or received insulin injections. RN #215 verified the MDS completed and signed by her on 04/23/26 for Resident #29 indicated item N0350 was answered 01 which indicated Resident #29 received insulin injections and that was incorrect and the answer needed modified to reflect 00 which indicated Resident #29 did not receive insulin injections. RN #215 made the modification to the MDS assessment at that time. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.Review of the medical record for Resident #55 revealed admission to facility on 01/10/26 for diagnoses of chronic respiratory failure, oxygen dependence, lung disease, fibromyalgia (chronic pain in various nerve endings), diabetes, depression, anxiety, high blood pressure, chronic kidney disease stage 4, gastric reflux, cirrhosis (scarring) of the liver, and new diagnoses of a pressure ulcer injury of right buttock on 03/21/26. Review of the most recent minimum data set (MDS) 3.0 quarterly assessment with assessment review date (ARD) of 04/29/26 for Resident #55 revealed item M0300 C2 was answered as 01 indicating presence of a stage three pressure ulcer present upon reentry to the facility. Review of the MDS 3.0 discharge from facility with anticipated return assessment completed on 03/19/26 revealed no current pressure injuries/ulcers. Review of the nursing assessment for Resident #55 completed on 03/21/26 after return to the facility by RN #223 revealed the presence of MASD (moisture associated skin damage) to the bilateral buttocks. There was no evidence of measurements or presence of any wounds or pressure injury documented. Review of the Nurse Practitioner (NP) history and physical completed by NP #300 on 03/26/26 revealed the presence of an unstageable pressure injury to the right buttock gluteal fold measuring 5.0 centimeters (cm) in length by 3.0 cm wide by 0.3 cm in depth and the wound bed was covered with 100% slough (a film of dead cells and white blood cells). Interview on 05/07/26 at 12:47 P.M. with RN #215 revealed the Matrix completed for Resident #55 on 05/04/26 did not have a stage three pressure ulcer/injury. After review of the medical records RN #215 verified Resident #55 did not have an unstageable pressure injury upon returning to the facility on [DATE] after a three-day hospital stay and was not noted in the medical record until 03/26/26. RN #215 modified the Matrix and the most current MDS 3.0 discharge assessment completed on 04/10/26 to reflect the correct answer of not having a pressure injury on most recent re-entry to facility. 4. Review of Resident #30's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included unspecified dementia, hypertension, and chronic kidney disease. Review of Resident #30's physician's orders revealed she was to receive Simvastatin (medication used to lower cholesterol levels in the blood) 10 milligrams (mg) po (oral) every night at bedtime for hypercholesterolemia (high cholesterol levels in the blood). The order had been in place since 06/18/24. Review of Resident #30's active care plans revealed she had a care plan in place for having hypercholesterolemia. The interventions included administering medications per physician's orders. Review of Resident #30's medication administration record (MAR) for March 2026 revealed the resident was documented as having received Simvastatin 10 mg by mouth (po) every night at bedtime as ordered. She was documented as having received the Simvastatin nightly between 03/10/26 and 03/16/26. Review of Resident #30's quarterly MDS assessment dated [DATE] revealed the assessor completing the MDS assessment was to code all active diagnoses the resident had in the past seven days. The section for metabolic diagnoses included a box to check, if the resident had the diagnosis of (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hyperlipidemia (e.g., hypercholesterolemia), but the box was left unchecked. On 05/07/26 at 9:25 A.M., an interview with the Director of Nursing (DON) confirmed Resident #30's quarterly MDS assessment completed on 03/16/26 was not coded accurately, as it did not identify the resident as having the diagnosis of hypercholesterolemia under her active diagnoses. He acknowledged Resident #30 had been receiving Simvastatin 10 mg po every night at bedtime for hypercholesterolemia during the seven day assessment period and her diagnoses coded on the MDS assessment should have reflected so.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on review of the facility dietary manual, observation, tasting of the pureed dinner items, and interview, the facility failed to ensure foods were prepared to an appropriate puree consistency. The had the potential to affect nine residents (Residents #3, #12, #17, #22, #27, #32, #56, #57, and #58) the facility identified as receiving a puree diet. The facility census was 52. Findings include:Observations on 05/05/26 between 1:12 P.M. and 1:50 P.M. of the pureed food preparation revealed dietary cook (DC) #231 had prepared beets, fruit cocktail, and grilled chicken for the dinner meal. All foods were processed in the robot coup (a specialized blender utilized to make pureed foods) for the puree process. DC #231 pureed nine premeasured servings of beets in the robot coup and then after visualizing the pureed beet consistency, began to place the beets into serving dishes for the dinner meal. The surveyor requested to taste the pureed beets to ensure were of pureed consistency. DC #231 stated she had never tasted pureed foods for consistency or taste. Tasting of the pureed beets revealed a crunchy texture in a semi thin liquid that was separated from the beets but tasted appropriate. DC #231 and Dietary Manager (DM) #209 verified the beets had a crunchy texture and not a smooth texture found with pureed food items. DC #231 returned the beets to the robot coup and pureed them several minutes longer and retasted prior to spooning into serving bowls.Review of the facility literature provided titled Pureed Diet, from Innovations Services Diet Manual published 2025 pages 37-39 revealed puree diets consist of foods that are smooth, cohesive, and require no chewing. Foods must be completely pureed to a smooth consistency to reduce the risk of chocking or aspiration. The manual further reads food characteristic for a pureed diet included: usually eaten with a spoon, cannot be drunk from a cup, cannot be slurped through a straw, does not require chewing, appears softly formed on a plate, no lumps, not sticky, liquid does not separate from solid, no biting or chewing required.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, and review of the facility policy, the facility failed to accommodate Resident #26 personal preferences of having a nightstand and personal toiletries in her bathroom. This affected one (Resident #26) out of two reviewed for accommodation of need. Facility census was 52.Findings include: Review of the medical record for Resident #26 revealed an admission date of 12/03/22 with diagnoses including chronic kidney disease stage 4, hypertension, bilateral hearing loss, and arthropathy. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #26 was cognitively intact and was independent with toileting hygiene, shower/bathing and personal hygiene. Review of the Activities of Daily Living (ADL) care plan revised 06/17/25, revealed Resident #26 requires assistance for ADL's in regard to advanced age, active wounds and requires an assistive device. Interventions included encourage and allow resident to complete self-care as able. An interview on 05/04/26 at 10:45 A.M. with Resident #26 stated she preferred to bathe herself, she used to have a stand in her bathroom with all of her toiletries and the staff removed it. Resident #26 stated she would like it back in the bathroom due to having to carry everything back and forth to the bathroom. Observation revealed Resident #26's nightstand was outside of the bathroom and her toiletry items were in her closet.There was nothing observed in the bathroom for the resident to use in place of the stand to accomodate the resident's preference. An interview on 05/07/2026 3:41 PM with the Director of Nursing (DON) verified Resident #26's nightstand and toiletry items were taken out of the bathroom and Resident #26 preferred it in there. The DON stated the stand was removed as part of a corporate survey and staff were told the stand could not be in the resident's bathroom. Review of facility policy titled, Quality of Life-Homelike Environment dated May 2017, revealed staff shall provide person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and staff interview, the facility failed to ensure a resident's care plan was revised to reflect the preference of the resident's family for the resident to not wear any splints, braces, or other orthotics as part of the resident's contracture management. This affected one (Resident #17) of 24 residents reviewed for care plans. Findings include:Review of Resident #17's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included hemiplegia (paralysis) and hemiparesis (weakness) affecting his left non-dominant side, muscle weakness, cognitive communication deficit, unspecified dementia, and mood disorder with depressive features. Review of Resident #17's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had adequate hearing and unclear speech. He was usually able to make himself understood and was usually able to understand others. His cognition was severely impaired and he was not known to display any behaviors or reject care. He had a functional limitation in his range of motion on one side of his upper extremities. He was not indicated to be receiving any therapy or restorative nursing services for range of motion at that time. Review of Resident #17's active care plans revealed he had a care plan in place for an alteration in his musculoskeletal status related to a left hand contracture and left hemiplegia. The care plan originated on 03/17/22. The goal was for the resident to remain free of any complications related to his left hand contracture as evidenced by no further contracture by the review date. The interventions included encouraging and assisting the resident with the use of supportive devices as ordered. The care plan was not revised to reflect any non-compliance with the use of any splints, braces, or other orthotics, as part of his contracture management for his left hand contracture. Review of Resident #17's physician's orders revealed the resident did not have any orders in place for the use of any splints, braces, or other orthotic devices, as part of his contracture management. He did have an order for active range of motion to be provided to an unspecified extremity, as part of a restorative program, that originated on 06/13/22. Review of Resident #17's progress notes for the past four months revealed there was no documentation pertaining to any refusals of the use of any splints, braces, or orthotics, as part of his contracture management program. On 05/05/26 at 10:26 A.M., an observation of Resident #17 noted him to be up in a specialty wheelchair (tilt in space wheelchair) in his room. He was reclined back and was noted to have his left arm drawn up and against his chest. He did not have any splints, braces, or other orthotic devices in place to his left hand/ wrist contracture. On 05/05/26 at 12:35 P.M., an interview with Rehab Director #301 revealed the facility had worked with getting Resident #17 splints and stuff in the past to address his contractures. They attempted to get splints for his left hand and the left knee. They had ordered all of that and received them, only to have the family decide they did not want the resident to use them, due to them causing him discomfort when wearing. They recently screened the resident again, and the occupational therapist recommended splints again. He had to inform the occupational therapist the resident's family would not allow them to use them. He indicated occupational therapy continued to work with the resident for gentle range of motion stretching, as part of his contracture management. On 05/05/26 at 2:15 P.M., an interview with the facility's Director of Nursing (DON) confirmed Resident #17's active care plans did not reflect the resident's family's wishes not to use any splints, braces, or orthotics as part of his contracture management. He acknowledged the resident's care plan for an alteration in musculoskeletal status related to his contracture of the left hand should have been revised to reflect the family's preference not to use any splints, braces, or other orthotics to manage the resident's contractures.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, physical therapy records review, and interviews the facility failed to provide a timely implement a functional management program for Resident #29. This affected one (Resident #29) of one resident reviewed for restorative therapy services. The census was 52. Findings Include:Review of the medical record for Resident #29 revealed admission to the facility on [DATE] for diagnoses including acute respiratory failure, depression, hyponatremia (low salt level in blood), gastrointestinal bleed, anemia, high blood pressure, and hepatic encephalopathy (water on the brain leading to confusion).Review of the Resident #29 medical record revealed a physician's order on 04/10/26 for physical therapy treatments dated 04/10/26 through 04/25/26.Review of the most recent minimum data set (MDS) 3.0 comprehensive assessment completed on 04/13/26 revealed Resident #29 had no hearing or visual deficits and was able to communicate with and understand others. Further review of the MDS 3.0 indicated a brief interview for mental status was conducted and Resident #29 had a score of 15/15 indicating no cognitive impairments. Resident #29 required the use of a mechanical lift for transfers and was dependent on staff for toileting, bathing, and dressing.Review of Resident #29 physical therapy discharge summary completed on 04/25/26 and authored by the rehab director, physical therapist (PT) #301 revealed Resident #29 was discharged from physical therapy services due to care manager or physician order. Further review of the discharge summary revealed recommendations were made for a Functional Maintenance Program (FMP) by PT #301.Review of the (FMP) Communication form for Resident #29, dated 04/25/26 and signed by PT #301, revealed recommendations were made for a FMP after physical therapy with a discharge date of 04/25/26.Further review of the FMP form revealed the program was to begin on 05/07/26. Review of the FMP progress note indicated the same. There was no explanation as to why there was a delay between the recommendation for the FMP and the implementation of the FMP. Review of the functional maintenance care plan initiated on 05/07/26 revealed active range of motion to all extremities of 10 reps for 3-5 sets daily, 6-7 times per week.Interview on 05/07/26 at 9:50 A.M. with PT #301 revealed Resident #29's insurance would not authorize any further treatments after 04/25/26 and Resident #29 had a total of 10 physical therapy sessions. Resident #29 needed a lot of encouragement to participate in physical therapy. PT #301 reported that he recommended a FMP for Resident #29 on discharge from therapy services for nursing to continue. PT #301 reported that he filled out a communication form and gave it to Licensed Practical Nurse (LPN) #241 who was in charge of setting up the FMP with nursing. PT #301 reported he would have provided the communication form to LPN #241 on 04/25/26.Interview on 05/07/26 at 1:30 P.M. with LPN #241 revealed confirmation that Resident #29 did not receive FMP from 04/27/26 through 05/07/26. LPN #241 reported that the FMP communication form provided by physical therapy to set up FMP was misplaced in the pile of papers on her desk and she did not review it until today, 05/07/26. LPN #241 verbalized that her normal practice was to establish the FMP the same day she received the FMP communication form from the therapy department or the next day. LPN #241 reported she was the nurse responsible for making the FMP care plan and notifying the nursing staff of the resident's need for the FMP. LPN #241 reported that the program would show up under the task section in the electronic medical record for the certified nurses' aides (CNA) to complete with the residents.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview and policy review the facility failed to ensure residents identified at risk for elopement and resided on a secured memory care unit did not exit the facility without staff knowledge, failed to ensure interventions for residents identified at risk for elopement were timely implemented and failed to ensure fall prevention interventions were in place. This affected three residents (Resident #39, #54 and #17) of six residents reviewed for accidents. Findings include: 1.Review of the medical record for Resident #39 revealed an admission date of 10/03/25 with diagnoses including Alzheimer's disease, dementia, epilepsy, Parkinsonism, intermittent explosive disorder, frontotemporal neurocognitive disorder, and muscle weakness. Review of the most recent quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #39 had severely impaired cognition and was unable to complete the interview. Resident #39 was assessed to ambulate independently. Review of Resident #39's wandering risk assessment dated [DATE] revealed the resident has wandered before, wandering places the resident at significant risk of getting to a potentially dangerous place, the resident is cognitively impaired, the resident was not a new admission, the resident is able to ambulate independently and the wandering has increased since the last evaluation. Review of Resident #39's wandering risk assessment dated [DATE] revealed the resident has wandered before, wandering places the resident at significant risk of getting to a potentially dangerous place, the resident is cognitively impaired, the resident was not a new admission and the resident is able to ambulate independently. Review of Resident #39's plan of care last revised on 10/29/25 revealed the resident was transferred from an assisted living environment to secure memory unit due to Alzheimer's disease and history of exit seeking. Interventions included but not limited to supervision will be provided at all times while off of the unit/and secured courtyard, staff will redirect and/or attempt diversional activities if she attempts to elope/wander off unit/facility. Further review of care plan, initiated date 03/25/26 and last revised 05/06/26 revealed resident was at risk for elopement and/or wandering. Interventions included elopement book will be current with Resident #39's picture, supervision will be provided at all times while off of the unit/and secured courtyard. Review of Resident #39's progress notes dated 03/25/26 at 9:40 A.M. authored by Registered Nurse (RN) #227 revealed resident was found wandering outside building in the front lot. No injury was noted on assessment. Review of the elopement timeline for Resident #39 revealed on 03/25/26 at 9:40 A.M. the resident was last seen by RN #227 at 9:30 A.M. for medication administration. Resident was found outside by therapy director # 301 at 9:40 A.M. in the parking lot. Facility staff conducted a head count on 03/25/26 and all residents were accounted for and present in the building. The Director of Nursing (DON), Administrator, physician, family and risk group were notified on 03/25/26. A wandering risk assessment and behavior assessment was completed by the DON/designee. A head-to-toe skin assessment was completed and no injuries were found. Staff were interviewed on 03/25/26. The care (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan was updated on or before 03/26/26. The maintenance Director fixed the door on 03/25/26 and a staff member was stationed at the door at all times until it was fixed. (The system was identified to not be closing correctly due to concerns with the magnetized lock). Interview on 05/06/26 at 2:50 P.M. with RN #227 revealed she had just administered Resident #39's medications right before the elopement. The Certified Nursing Assistant (CNA) # 207 was off the unit assisting another resident with a shower. The therapy director # 301 found the resident outside in the parking lot. We looked at the door, it was alarming and come to find out the magnet had slipped (the system was not closing properly). The Maintenance Supervisor # 223 fixed it immediately. Interview on 05/06/26 at 3:15 P.M. with Therapy Director #301 revealed he found Resident #39 outside in the parking lot in front of the building around 9:40 A.M. and he assisted her back inside. 2. Review of the medical record for Resident #54 revealed an admission date of 04/28/26 with diagnoses including vascular dementia with mood disturbance, unspecified mood (affective) disorder, and violent behavior Review of Resident #54's initial wandering risk assessment dated [DATE] indicated he has wandered before, his wandering placed him at significant risk of getting to a potentially dangerous place, cognitively impaired, ambulates independently and wandering is not a new behavior. Review of the care plan initiated 05/05/26 revealed Resident #54 uses a wander guard to right lower leg related to wandering episodes, no awareness of safety needs and diagnosis of vascular dementia. Interventions included evaluate wander guard use, evaluate/record continuing risks/benefits, alternatives, need for ongoing use and reason for use; he needs a safe environment with adequate, glare-free light, floors that are even and free from spills or clutter; call light, personal items in reach and monitor/document/report as needed any changes regarding effectiveness of wander guard, less restrictive device, if appropriate; any negative or adverse effects noted, including; decline in mood, and change in behavior. Review of Resident #54's wandering risk assessment dated [DATE] indicated he has wandered before, his wandering placed him at significant risk of getting to a potentially dangerous place, cognitively impaired, ambulates independently, wandering is not a new behavior, and the incidence of wandering has increased since the last evaluation. Observation on 05/06/26 at 11:28 A.M. Resident #54 exited through the front door of the facility. The alarm sounded and the Director of Nursing (DON) and Respiratory therapy Director #273 responded within one minute. Interview on 05/06/26 at 12:16 P.M. with Certified Nursing Assistant (CNA) #263 revealed Resident #54 frequently exit seeks. She stated he wandered a lot. CNA#263 stated Resident #54 has not been out of his room much today. CNA #263 was not aware Resident #54 exited through the front door. Review of the elopement binder on 05/06/26 at 12:07 P.M. with the DON verified no information was in the binder for Resident #54. Further review of the elopement binder revealed current information related to resident's at risk for elopement, including a current photograph and the binder was located at the front desk for staff to access. Interview on 05/06/26 at 3:30 PM with Resident #54's spouse revealed the facility spoke to her (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regarding his wandering behaviors and asked for her to refrain from taking him outside during visits to help him adjust to the transition. The spouse also stated the wander guard was not implemented until Monday 05/04/26. Review of facility policy titled Elopements, revised December 2007 revealed staff shall investigate and report all cases of missing residents. Review of facility policy titled Wandering, Unsafe Resident, revised August 2014 revealed the staff will identify residents who are at risk for harm because of unsafe wandering (including elopement). The staff will assess at-risk individuals for potentially correctable risk factors related to unsafe wandering. The resident's care plan will indicate the resident is at risk for elopement or other safety issues. Interventions to try to maintain safety, such as detailed monitoring plan will be included. 3. Review of Resident #17's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included unspecified dementia, hemiplegia (paralysis) and hemiparesis (weakness) following a stroke affecting his left non-dominant side, age-related osteoporosis, cognitive communication deficit, and muscle weakness. Review of Resident #17's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had unclear speech. He was usually able to make himself understood and was usually able to understand others. His cognition was severely impaired and he was not known to display any behaviors or reject care. He had a functional limitation of his range of motion on one side of his upper and lower extremities. Partial/ moderate assist was needed with bed mobility and he was dependent on staff for transfers. Review of Resident #17's active care plans revealed he had a care plan in place for being at risk for falls related to left hemiplegia, poor sitting balance, confusion, incontinence, medication use, seizure disorder, non-ambulatory, and having a custom tilt-in-space wheelchair. The care plan originated on 07/29/15. The goal was for the resident to have a decreased risk of a serious fall related injury through the next review. The interventions included padded bilateral half side rails to bed, bed changed with bed frames and function audit (03/14/24, recline chair when up (except for meals), and a soft touch call light kept within reach. Review of Resident #17's physician's orders revealed he had an order in place for the use of a low bed. The order had been in place since 10/29/20. He also had the use of fall mats on the floor to both sides of the bed that originated on 04/05/22. Review of Resident #17's treatment administration record (TAR) for May 2026 revealed the nurses were initialing the TAR to reflect the use of a low bed every shift. On 05/04/2026 at 1:53 P.M., an observation of Resident #17 noted him to be lying in the bed next to the window. The bed was in a raised position that was higher than the height of a normal bed. He was noted to have fall mats on the floor on each side of his bed. On 05/05/26 at 1:50 P.M., a follow up observation of Resident #17 noted him once again to be lying in bed by the window with the bed in a raised position. The height of the bed was not as high as with the previous observation, but it was still not in it's lowest position. He continued to have fall mats on the floor on each side of the bed. Findings were verified by LPN #239. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/05/26 at 1:51 P.M., an interview with LPN #239 revealed she considered Resident #17 to be at risk for falls, but she considered all residents to be at risk for falls. She was asked what interventions were in place for the resident to prevent falls. She stated she would have to check the resident's chart to see what fall prevention interventions were in place. She went to the computer and reviewed the resident's physician's orders and care plan to identify what fall prevention interventions were in place. She identified the resident had the use of a low bed, as one of his fall prevention interventions. She accompanied the surveyor back to the resident's room and confirmed he was not in a low bed, nor was the bed he was in in it's lowest position. The frame on the bed the resident was in was approximately 16 inches off the floor. The nurse was able to lower the bed about eight inches, so the bed was able to be lowered to the frame only being about eight to nine inches off the floor. On 05/05/26 at 2:05 P.M., an interview with the DON confirmed the resident was supposed to be in a low bed per his plan of care. He acknowledged the resident was observed yesterday, and again today, to be in bed when the bed was not in its lowest position. Review of the facility's policy on Falls- Clinical Protocol revised September 2012 revealed, as part of the initial assessment, the physician would help identify individuals with a history of falls and risk factors for subsequent falling. If interventions have been successful in preventing falling, the staff would continue with current approaches or reconsider whether those measures were still needed if the problem that required the intervention had resolved.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records, review of facility investigation, observations, interviews, facility assessment review and policy review the facility failed to provide comprehensive, resident centered dementia care to prevent resident to resident physical abuse. This affected two residents (Resident #14 and #32) of two residents reviewed for abuse. The facility census was 52. Findings include:a. Review of the medical record for Resident #14 revealed admission to facility on 03/01/24 for diagnoses including Alzheimer's disease (impaired short term memory and ability to communicate), gastric reflux, Dementia (confusion and forgetfulness) with moderate behavior disturbances, post traumatic stress disorder, depression, and spinal stenosis (narrowing of canal the spinal cord is in the spinal vertebra). Further review of the medical record revealed Resident #14 resided on the locked memory care unit.Review of the most recent minimum data set (MDS) 3.0 quarterly assessment dated for Resident #14 revealed a brief interview for mental status score of 5/15 indicating severe cognitive impairment. Further review of the MDS revealed no current delusion or hallucinations. Resident #14 was independent with walking without a device and only required supervision for safety concerns.Further review of a nursing progress note dated 03/02/26 at 6:31 P.M. for Resident #14 revealed Resident #14 was inserting herself into other individual conversations and blocking staff from moving about the unit and would become angry when redirected.Review of a nursing progress note dated 03/19/26 at 9:45 P.M. revealed Resident #14 attempted to go out the back door with another resident earlier in shift then escalated her behaviors to the point she grabbed another resident's hair and tried to pull her out of bed. Resident #14 then began targeting other residents and the provider was notified and an order was given for Haldol 5 milligrams intramuscular (injection into a large muscle) x one dose.b. Review of the medical record for Resident #32 revealed admission to the facility on [DATE] for diagnoses including unspecified dementia without any behavioral disturbances, depression, diabetes, glaucoma (disease affecting eye pressure and vision), and poor circulation. Further review of the medical record indicated Resident #32 resided on the locked memory care unit.Review of the most recent MDS 3.0 quarterly assessment completed on 04/07/26 revealed Resident #32 had a brief interview for mental status score of 5/15 indicating severe cognitive impairment and the presence of inattention and disorganized thinking. Resident #32 relied on staff for assistance with bathing, dressing, toileting and personal care. Resident #32 used a wheelchair pushed by staff.Review of the care plan for Resident #32 revealed an active care plan initiated on 02/28/25 related to diagnosis of dementia and history of wandering behavior and attempted elopements requiring secured memory unit. Interventions included attempt to find out why resident is attempting to elope/wander, administer medications as ordered, allow Resident #32 to ambulate freely in secured memory unit, staff to redirect and attempt diversional activities if attempting to leave unit, and supervision will be provided at all times while Resident #32 is off of the secured memory unit or secured courtyard.Review of the facility self-reported incident investigation summary reported to the Ohio Department of Health on 03/20/26 revealed on 03/19/26 CNA #229 reported that Resident #14 had an altercation with Resident #32 in which Resident #14 followed the CNA #229 in the room of Resident #32. Resident #14 then reached around CNA #229 and pulled Resident #32 hair and tried to pull her out of bed. CNA #229 was able to redirect Resident #14 and notified the nurse on duty, LPN # 232. LPN #232 assessed Resident #32 and no injuries were noted. Further review revealed interventions were updated on the care plan to include a stop sign on the door of Resident #32. All physicians and emergency contacts were notified of incident and assessments. The summary continues to say out of an abundance of caution all facility staff was retrained on abuse prevention and abuse policy.Review of the resident post incident interviews revealed that neither Resident #14 nor Resident #32 could recall the event due to poor cognition/memory.Review of the staff statements (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regarding the incident revealed on 03/19/26 LPN #232 stated Resident #14 had been having behaviors without success of redirection. LPN #232 further stated that Resident #14 had been pacing the halls. LPN #232 did not witness the event and it was reported to her by CNA #229. LPN #232 called the nurse practitioner on duty and reported Resident #14 behaviors and was given a one-time order to administer an injection of Haldol (anti-psychotic medication that has a sedative effect). Resident #14 then slept the remainder of the night.Review of the staff statements further revealed CNA #229 stated that she had just put Resident #32 into bed and Resident #14 came into the room and reached around her and pulled the hair of Resident #32. CNA #229 stated Resident #14 left the room, and she made sure Resident #32 was okay and went and told the LPN #232 what happened.Review of staff statements completed by the Administrator via phone for staff members CNA #303, CNA #304 and RN #260 revealed they were not on the memory care unit at the time of the incident occurred. There was no witness statement from CNA #200 who was assigned to work the memory care unit that day.Review of the daily census/staffing sheet dated 03/19/26 revealed at the time of the incident the facility had one nurse, LPN #232 covering the north hall and the memory care unit, and one RN #260 covering the south unit. There were four CNA's working, one on north hall, CNA #303, one on memory care unit, CNA #200, and two on south hall CNA #229 and CNA #304.Observation on 05/05/26 at 12:17 P.M. revealed Resident #14 walking out of the dining room of the locked memory care unit and smiling and talking non-sensical to other residents and staff. Resident #14 quickly came up to the surveyor behind the nurse's desk and attempted to hug the surveyor. Resident #14 was able to be redirected, and the aide assisted in directing Resident #14 out of the nurse's area and to sit down in chairs in hallway. Resident #14 would only set momentarily and then would get up and begin engaging with others.Interview on 05/07/26 at 3:50 P.M. via phone with LPN #232 revealed she did not witness the incident and it was reported to her by CNA #229 that Resident #14 followed her into Resident #32 room and attempted to pull Resident #32 out of bed and pulled her hair.Further interview revealed that LPN #232 reported that Resident #14 has a history of targeting Resident #32 and they often have to be separated because Resident #14 will pick at Resident #32. Resident #14 can be more difficult to redirect, and Resident #32 knows how Resident #14 can be and will try to avoid her. LPN #232 confirmed that Resident #14 was having a lot of behaviors that day and LPN # 232 had to call the provider to get an order for Haldol because Resident #14 was not consolable with her behaviors that shift.Continued interview with LPN #232 revealed that normal staffing ratios for the 7:00 P.M. to 7:00 A.M. shift were one nurse to cover the north hall and the locked memory care unit and one CNA on the north hall and one CNA on the memory care unit. LPN #232 confirmed that there was often only one staff member (the CNA) on the memory care unit during the night shift to supervise all the residents and this is difficult especially when residents are known to have behaviors.Interview on 05/07/26 at 3:36 P.M. via phone with CNA #229 revealed at the time of the incident with Resident #14 and #32 she was the only staff member present on the memory care unit. CNA #229 confirmed that Resident #14 came into Resident #32's room while she was putting her to bed and reached around the CNA and pulled Resident #32's hair. CNA #229 confirmed the staffing ratios for the memory care unit from 7:00 P.M. to 7:00 A.M. were usually one CNA and one nurse to cover the memory care unit and the north hall making it difficult to supervise all the residents while assisting residents in their room and implementing appropriate dementia care to prevent potential behaviors.Interview on 05/06/26 at 2:35 P.M. with CNA #207 revealed that she works mostly on the memory care unit and has been employed at facility for over three years. CNA #207 reported that Resident #14 often gets into it with Resident #32 verbally and the two residents have to be separated. CNA #207 reported that Resident #32 is better about avoiding Resident #14. CNA #207 reported that the other day Resident #32 was in her wheelchair in the dining room and Resident #14 tried to get her wheelchair and pull her out of the dining room and she had to redirect Resident #14 and remind her to keep her hands to herself. CNA #207 confirmed there generally is only one CNA on the unit at night and the nurse goes back and forth from the memory care unit and the north hall. This makes it difficult to supervise the residents and (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assist other residents with needed care in their room or away from an area to monitor residents especially when behaviors are occurring or may occur. The CNA also verified it is difficult to implement dementia care when only one staff is available for the residents on the secured unit.Review of the facility assessment dated [DATE] revealed the facility has an Alzheimer's/Dementia Secured Specialty Unit of 20 beds. This unit includes staff that has received training for a cognitively impaired residents and Alzheimer's/Dementia residents. Staff training/education and competencies and skill sets of the following training topics: for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.Review of the facility Abuse and Neglect Protocol, revised 06/13/21 revealed the following definitions of abuse to ensure recognition and reporting, misconduct, is improper, egregious, potentially dangerous behavior, abusive/offensive language or gestures directed toward or in front of a resident. The protocol further reveals the facility will not condone resident abuse by anyone including other residents.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, record review, and review of facility policy, the facility failed to ensure physician-ordered medication parameters were followed for use of a narcotic pain medication and a heart rate was monitored as ordered prior to administration of medication. This affected two (#30 and #33) of five residents reviewed for unnecessary medications and medication review. The facility census was 52.Findings include: 1.Review of the medical record for Resident #33 revealed an admission date of 07/31/25 with diagnoses including repeated falls, low back pain, spinal stenosis, lumbar region without neurogenic claudication, and intervertebral disc degeneration, lumbar region with discogenic back pain only. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) had intact cognition. The resident was assessed to frequently have pain. Review of the plan of care last revised 08/18/25 revealed Resident #33 is at risk for developing complications secondary to is on pain medication therapy related to repeated falls, wedge compression fracture-lumbar, low back pain, spondylosis, spinal stenosis, right knee arthritis and degenerative disc disease-lumbar. Interventions included administer medication as ordered and review regularly for pain medication efficacy. Review of Resident #33's physicians orders dated 08/14/25 revealed an order for Acetaminophen (Tylenol) oral tablet 500 milligrams (mg) give one tablet by mouth every six hours as needed for pain and an order dated 09/08/25 for Percocet (narcotic pain medication) Oxycodone with Acetaminophen 5/325mg give one tablet by mouth every eight hours as needed for severe pain level 6-10 (on a pain rating scale of 1-10 with 1 representing minimal pain and 10 representing the worst pain ever felt). Review of the medication administration record (MAR) for January 2026 revealed Percocet was administered outside of parameters on January 1, 2, 7, 10, 11, 12, 14, 15, 16, 17, 18, 27, 29, and 30. Review of the medication administration record (MAR) for February 2026 revealed Percocet was administered outside of parameters on February 1, 3, 4, 9, 10, 12, 15, 16, 17, 18, 19, 20, 22, 23 and 26. Review of the medication administration record (MAR) for March 2026 revealed Percocet was administered outside of parameters on March 1, 2, 5, 6, 7, 12, 13, 15, 16, 19, 20, 21, 22, 23, 25 and 30. Review of the medication administration record (MAR) for April 2026 revealed Percocet was administered outside of parameters on April 2, 3, 4, 5, 6, 7, 10, 11, 12, 14, 15, 16, 17, 19, 20, 21, 22, 25, 26, 27 and 28 Review of the medication administration record (MAR) for May 2026 revealed Percocet was administered outside of parameters on May 4th and 5th. On 05/05/26 at 8:59 A.M. Resident #33 stated she doesn't ask for a specific pain medication. The resident stated she requests a pain pill when having pain. Interview on 05/07/26 at 11:04 A.M with Registered Nurse (RN) #215 stated when two pain (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications were ordered the facility will have parameters for both pain medications. RN #215 verified Resident #33 was administered pain medications outside of the ordered parameters and not per physicians order. Review of the facility's policy on Administering Medications revised April 2019 revealed medications were to be administered in a safe and timely manner, and as prescribed. The individual administering the medication was to check the label three times to verify the right resident, the right medication, right dosage, right time, and the right method (route) of administration before giving the medication. 2. Review of Resident #30's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included hypertension and atrial fibrillation. Review of Resident #30's physician's orders revealed she had an order to receive Toprol XL Extended Release (beta-blocker used to treat high blood pressure) 50 milligrams (mg) by mouth (po) once daily in the morning related to essential hypertension. The order included parameters to hold the medication if the resident's heart rate was less than 60 beats per minute (bpm). Review of Resident #30's medication administration record (MAR) for April and May 2026 revealed the resident was receiving Toprol XL 50 mg po every morning for hypertension as ordered. The MAR included a place for the nurses to include their initials to show when the medication had been received. There was no place on the MAR for the nurse to document the resident's heart rate to show evidence they were monitoring the resident's heart rate and following the parameters included in the order for which the medication should be held. Further review of Resident #30's medical record revealed there was no documented evidence of the resident's heart rate being checked daily that coincided with the times the resident received her Toprol XL. There were some pulses recorded under the vital sign tab of the electronic medical record, but they were not being consistently obtained and recorded for the times the Toprol XL was received. On 05/07/26 at 9:25 A.M., an interview with the Director of Nursing (DON) confirmed Resident #30's order for Toprol XL that was to be administered every morning for hypertension did include parameters to hold the medication, if the resident's heart rate was less than 60 bpm. He could not find evidence of the nurses monitoring the resident's heart rate prior to the administration of that medication to show they were following the parameters included in the order.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, staff interview, and policy review, the facility failed to ensure their medication error rate did not exceed 5%. The facility had three errors out of 33 opportunities for a medication error rate of 9%. This affected two (Resident #25 and #31) of four residents reviewed during medication administration observations. Findings include: 1. On 05/06/26 at 8:10 A.M., a medication administration observation was completed for Resident #25 of medications administered by Registered Nurse (RN) #227. The nurse was observed to administer the morning medications that were scheduled for the resident on that day. The resident received six medications to include Amlodipine 5 milligrams (mg) by mouth (po) as ordered once daily, Plavix 75 mg po as ordered once daily, Isosorbide Mononitrate ER 60 mg po as ordered once daily, Multiple Vitamin with Minerals po as ordered once daily, Senna Plus 8.6 mg- 50 mg po as ordered once daily, and Metoprolol Tartrate 25 mg po as ordered twice daily. Review of Resident #25's physician's orders revealed, in addition to the above medications, the resident was also to receive Ferrous Sulfate 325 mg po once daily. The medication had been ordered since 06/20/24. Review of Resident #25's medication administration record (MAR) for May 2026 revealed the Ferrous Sulfate 325 mg tablet was scheduled to be given once daily at 8:00 A.M. The nurse that was observed to administer Resident #25 her medications signed the MAR to reflect the Ferrous Sulfate had been given despite observations indicating otherwise. On 05/06/26 at 9:28 A.M., findings were verified with RN #227 that she did not administer a Ferrous Sulfate 325 mg tablet to the resident that morning when she was observed to give Resident #25 her morning medications. She stated she must have just missed that medication and indicated it would have come from a stock bottle if she had pulled it for administration. 2. On 05/06/26 at 8:15 A.M., a medication administration observation was completed for Resident #31. The medications due during the morning medication administration pass was provided by RN #227. The resident was given eight medications that included Aspirin (ASA) Enteric Coated (EC) 81 mg tablet and a Vitamin D 10 micrograms (mcg) tablet among the eight different medications received. Both medications were pulled from a stock bottles from the medication administration cart. Review of Resident #31's active physician's orders revealed the resident was to receive ASA EC 81 mg tablets with directions to give two tablets (162 mg) by mouth once daily for heart health. The order had been in place since 07/30/24. The orders also included the need to administer Cholecalciferol (Vitamin D) 25 mcg tablets with directions to give two tablets (50 mcg) one time a day for a Vitamin D deficiency. Based on the observation and the reconciliation of the resident's medication orders, the resident received half the dose she should have been given for the EC ASA and a fifth of the ordered dose for the Vitamin D. On 05/06/26 at 9:30 A.M., an interview with RN #227 confirmed she only administered one (81 mg) tablet of EC ASA when giving Resident #31 her morning medications. She acknowledged the current physician's orders was to give the resident two (81 mg) tablets of EC ASA to equal 162 mg. She reported she had never seen an order to give a resident two EC ASA 81 mg tablets before, so she just assumed that the resident was to receive one tablet. She further confirmed she only gave the resident 10 mcg of Vitamin D when 50 mcg were ordered every morning. She reported they did have a stock bottle of Vitamin D 25 mcg tablets in the medication administration cart earlier, but she used the last tablet on one of the other two halls she was passing medications on. She acknowledged even with that, she would have still only given half the ordered dose, if she only gave one tablet of the 25 mcg Vitamin D tablets. She further acknowledged, since she gave a 10 mcg tablet of Vitamin D to the resident, she only administered one-fifth of the ordered dose. Review of the facility's policy on Administering Medications revised April 2019 revealed medications were to be administered in a safe and timely manner, and as prescribed. The individual administering the medication was to check the label three times to verify the right resident, the right medication, right dosage, right time, and the right method (route) of administration before giving the medication.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, staff interview, and policy review, the facility failed to ensure a nurse followed appropriate hand hygiene practices after administering eye drops to one resident (Resident #31) and before preparing medications for another resident (Resident #11). The facility's census was 52. Findings include: On 05/06/26 at 8:15 A.M., a medication administration observation for Resident #31 noted her medications to be prepared and administered by Registered Nurse #227. Among the medications administered was Artificial Tears Opthalmic solution 0.2- 0.2-1%. The nurse was observed to enter the resident's room to give the resident her morning medications. She gave the resident her pills first, followed by the eye drops, administering one drop into both the resident's eyes before leaving the room. She was not observed to wash her hands with soap and water or to use hand sanitizer when leaving the room, or before returning to the medication administration cart to begin preparing Resident #11's medications for administration. On 05/06/26 at 8:24 A.M., an interview with RN #227 confirmed she did not perform any hand hygiene after she administered eye drops to Resident #31 or before she started to prepare the medications she was about to administer to Resident #11. She acknowledged she should have performed hand hygiene between the two residents' medication administrations. She stated they did not have hand sanitizer in the hallways, but usually had some on their medication administration cart. She reported she did not have any hand sanitizer on the medication administration cart that morning. She further acknowledged the potential to spread infections between residents when administering medications by failing to follow appropriate infection control policies and good hand hygiene practices. Review of the facility's policy on Administering Medications revised April 2019 revealed medications were to be administered in a safe manner. Staff were to follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves etc._ for the administration of medications, as applicable. Review of the facility's policy on Instillation of Eye Drops revised January 2014 revealed the purpose of the procedure was to provide guidelines for installation of eye drops to treat medical conditions, eye infections, and dry eyes. The general guidelines indicated should both eyes require instillation, wash and dry hands thoroughly before treating each eye. Steps in the procedure included the need to wash and dry hands thoroughly before donning gloves. They were to remove gloves and wash/ dry hands thoroughly, after the eye drops were administered.

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to ensure residents were provided appropriate notices when transferred to the hospital and the State's local Ombudsman was notified of all transfers/ discharges from the facility as required. This affected three (Resident #45, #51, and #53) of three residents reviewed for hospitalizations and/ or planned discharges. Findings include:1. Review of Resident #51's medical record revealed he was admitted to the facility on [DATE]. He was hospitalized on three separate occasions, during his stay in the facility, with the hospitalizations occurring between 02/23/26 and 03/03/26, 03/31/26 and 04/02/26, and again on 04/10/26, in which he did not return to the facility. Review of Resident #51's progress notes revealed a nurse's note dated 02/23/26 at 11:01 P.M. that indicated the resident was found in bed with his tracheostomy tube out at 9:45 P.M. 911 was called and the resident was transferred to a local hospital to have the tracheostomy tube put back in. The local hospital was not able to insert a new tracheostomy tube requiring him to be transferred to another hospital. The other hospital had him on a nasal cannula supplying him with oxygen and the resident was reportedly doing fine, but the family did not want him sent home, as the hospital planned, and wanted the tracheostomy tube put back in due to the resident's inability to clear his own secretions. He was then admitted to the hospital's surgical floor with an ENT (ears, nose, and throat) consult pending for re-insertion of the tracheostomy tube. While at the hospital, the resident was noted to have a fever, developed a lot of mucous, and found to have aspiration pneumonia. He returned to the facility on [DATE]. Review of Resident #51's progress notes revealed a nurse's progress note dated 03/31/26 at 2:20 P.M. that indicated the resident was found non-responsive with an elevated blood glucose level of 325 milligrams (mg)/ deciliter (dl). His other vital signs were relatively unremarkable with a blood pressure of 132/ 73 mm/Hg and a pulse of 96 beats per minute. His advanced level provider was contacted and a new order was received to send the resident to the emergency room for an altered mental status. Review of a physician/ nurse practitioner note for a Discharge summary dated [DATE] at 10:42 P.M. revealed the nurse practitioner (NP) was notified Resident #51's blood sugar was in the higher 400's (80-120 mg/dl being within normal limits) and the nursing staff gave him insulin coverage. The resident's blood sugar then raised to 525 mg/dl. At first the resident was asymptomatic, but he became lethargic requiring him to be transferred to the hospital. He was admitted to the hospital with lethargy and hyperglycemia (elevated blood sugar). The NP planned to change his enteral tube feedings upon his return to the facility. Review of a nurse's progress note dated 04/02/26 at 4:16 P.M. revealed Resident #51 returned from the hospital with new orders for Doxycycline and Augmentin (both antibiotics) for the treatment of a urinary tract infection and pneumonia. He was also indicated to be alert and at his baseline. Review of a nurse's progress note dated 04/10/26 at 4:15 P.M. revealed the nurse was notified by the respiratory therapist that the resident was not responding verbally. He was only able to open his eyes when spoken to and was found to be tachycardic (elevated heart rate). His family and the NP was notified and wanted the resident transferred to the local hospital for an evaluation. (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	Review of a nurse's progress note dated 04/11/26 at 12:04 A.M. revealed the facility nurse contacted the local hospital for an update on the resident's condition. The nurse was informed Resident #51 was awaiting a transfer to another hospital with the diagnosis of sepsis (systemic blood infection), urinary tract infection (UTI), and an altered mental state. The facility was later informed on 04/14/26 at 2:34 P.M. that the resident's daughter did not want to hold a bed for the resident's future return. The family was wanting the resident to be transferred to a nursing facility that was closer to their home. Resident #51 did not return to the facility, after his transfer to the hospital on [DATE]. Further review of Resident #51's medical record revealed there was no documented evidence of the resident and his representative being provided with a transfer notice for any of the three transfers (02/23/26, 03/31/26, and 04/10/26) he had to the hospital during his stay at the facility. There was also no evidence of the State's local Ombudsman being notified of the resident's transfer to the hospital on [DATE]. The facility provided a copy of the list of transfers, discharges, and deaths that occurred during the month of March 2026 that had been sent to the local Ombudsman via email on 04/08/26 at 9:41 A.M. with the resident's name not being included despite his transfer to the hospital on [DATE]. Findings were verified by the Director of Nursing (DON). On 05/07/26 at 3:00 P.M., an interview with the DON and Regional Nurse #245 revealed the facility had no evidence of a transfer notice being provided to Resident #51 or his representative for any of the three hospital transfers the resident had during his stay at the facility. They were not aware there was a transfer notice that needed to be provided to the residents and their representatives with any transfer to the hospital that occurred during a resident's stay in the facility. They further confirmed Resident #51's transfer to the hospital on [DATE] was not included on the list of transfers, discharges, and deaths that was sent to the local Ombudsman notifying them of the transfers and discharges for the month of March 2026. Review of the facility's policy on Transfer or Discharge Notices revised 07/30/25 revealed residents and/ or representatives were to be notified of an impending transfer or discharge and the reasons for the move in writing and in a language and manner they understood. A copy of the notice was to be sent to the Office of the State Long-Term Care Ombudsman, as well. In the event of an immediate transfer being required, due to a resident's urgent medical needs, the notice of transfer was to be given as soon as practical. 2.Review of the medical record for Resident #45 revealed an admission date of 10/18/25 with a most recent hospital stay of 01/31/26 to 02/09/26 with diagnoses including chronic respiratory failure with hypoxia, anxiety disorder, chronic obstructive pulmonary disease, dependence on supplemental oxygen and hypertension. Review of physician orders dated 01/31/26 revealed an order to send the resident to the emergency room (ER) for vomiting and abdominal pain. An assessment dated [DATE] at 10:00 P.M. revealed Resident #45 had a change in condition and was sent to the emergency room for a change of condition. There was no evidence of a transfer notice or a bed hold notice was provided to the resident and/ or her family at/ or around the time of his transfer in Resident #45's medical record. Interview on 05/07/26 at 3:37 P.M. with the Administrator verified the facility did not have a transfer notice or a bed hold notice for Resident #45's transfer to the hospital on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366261	A. Building B. Wing	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Enclave at Barnesville	400 Carrie Avenue Barnesville, OH 43713

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	3. Review of the medical record for Resident #53 revealed an admission date of 03/02/26 with a most recent hospital stay of 02/22/26 and a discharge date of 03/21/26 with diagnoses including fracture of left femur, difficulty in walking, chronic pain and chronic respiratory failure with hypoxia. Review of a progress note for Resident #53 dated 03/21/26 revealed the resident was discharged home with son. Interview on 05/07/2026 at 12:40 P.M. with the Director of Nursing (DON) revealed there was no evidence the Ombudsman was notified. Interview on 05/07/26 at 2:50 P.M. with the Office of the Long-Term Care Ombudsman verified there was no notification of Resident #53's discharge. Review of facility policy titled Transfer or Discharge Notices, revised 07/30/25 revealed residents (or resident representatives) are notified of an impending transfer or discharge and the reasons for the move in writing and in language and manner they understand. A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman.